VA MEDICAL FACILITIES CONSTRUCTION PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON

HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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CONTENTS

DECEMBER 14, 1982

Page

VA medical facilities construction program 1

STATEMENTS OF COMMITTEE MEMBERS

Chairman Ron Mottl 1

WITNESSES

Alvarez, Everett, Jr., Deputy Administrator, Veterans Administration, accompanied by John Murphy, General Counsel, Dr. William Jacoby, Deputy Chief Medical Director, William Sullivan, Associate Deputy Administrator for Logistics, and William Salmond, Assistant Deputy Administrator, Office of Construction 19
  Prepared statement of Mr. Alvarez 82
Brinsky, Gabriel P., national service and legislative director, AMVETS 58
  Prepared statement of Mr. Brinsky 396
DeGeorge, Frank R., associate legislative director, and Mr. Earl Kelly, associate legislative director, Paralyzed Veterans of America 54
  Prepared statement of the Paralyzed Veterans of America 364
Frenzel, Hon. Bill, a Representative in Congress from the State of Minnesota .. 16
  Prepared statement of Congressman Frenzel 80
Nelson, Hon. Bill, a Representative in Congress from the State of Florida 50
Peterson, Robert A., Senior Associate Director, Human Resources Division, U.S. General Accounting Office, accompanied by Norman Robkin 3
  Prepared statement of Mr. Peterson 61
Schwab, Donald H., Director, national legislative service, Veterans of Foreign Wars of the United States 56
  Prepared statement of Mr. Schwab 388
Sommer, John F., Jr., deputy director, national veterans affairs and rehabilitation commission, The American Legion, accompanied by Paul S. Egan, deputy director, national legislative commission, The America Legion 52
  Prepared statement of Mr. Sommer and Mr. Egan 353

MATERIAL SUBMITTED FOR THE RECORD

Letters:
  To Chairman Mottl from 10 Members of Congress expressing concern over the fate of the Minneapolis VA hospital 17
  To VA from Hon. Daniel A. Mica, re VA's 30-year Study of the Medical Needs of Veterans in Florida 282
  To Hon. Ron Mottl from The American Legion regarding Bronx, New York VAMC 321
Reports:
  GAO's observation on extent and cost of change orders to VA medical facility construction contracts 68
  VA's construction process: issues for consideration submitted by GAO 10
  Assessment of facility needs of VA medical centers 95
  Progress Report on implementation of Public Law 97-101 289
  Regional offices within 50 miles of VA medical centers 419
Visitation report of the American Legion on the Bronx, N.Y. VAMC 324
List of major VA medical construction projects for revalidation 406

Page

Statements:
- Hon. Rudy Boschwitz, a U.S. Senator from the State of Minnesota 349
- Hon. Berkley Bedell, a Representative in Congress from the State of Iowa 351

Study:
- A 30-year study of the needs of veterans in Florida 291
- Revalidation study 406

Questions:
- Hon. John Paul Hammerschmidt to VA Deputy Administrator Everett Alvarez 343

VA MEDICAL FACILITIES CONSTRUCTION PROGRAM

TUESDAY, DECEMBER 14, 1982

U.S. House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, D.C.

The subcommittee met, pursuant to call, at 8:30 a.m., in room 334, Cannon House Office Building, Hon. Ronald M. Mottl (chairman of the subcommittee) presiding.

Present: Representatives Mottl, Edgar, Applegate, Mica, Daschle, Hillis, and Dunn.

OPENING STATEMENT OF CHAIRMAN MOTTL

Mr. Mottl. Good morning. The Subcommittee on Hospitals and Health Care will come to order.

This morning we are conducting an oversight hearing on the VA medical construction program. Members will recall that the General Accounting Office submitted a report on December 30, 1981, dealing with reduction in the cost of building VA medical facilities. This review of the VA's medical construction program was conducted by the GAO at my request.

The subcommittee was and remains concerned about the constant increase in the cost of constructing VA medical facilities due to change orders initiated after entering into construction contracts and cost overruns. The data furnished by the GAO in this report came from the review of 10 randomly selected major construction projects. The GAO reported that the actual construction cost averaged 74 percent higher than the original estimates submitted to the Congress. Surprisingly, change orders to these construction projects resulted in an increase of only 7 percent, but this is a significant amount of money when you consider the magnitude of the construction program in the VA.

In a report issued in December 1974, the House Appropriations Committee found major hospital construction projects averaged cost overruns of 81 percent when compared to the original budget submission to the Congress. Individual project cost estimates increased as much as 391 percent. Needless to say, cost overruns of this magnitude cause this subcommittee serious concern. Reports such as these led to the enactment of title III, Public Law 96-22, in June 1979. This title requires the VA to submit annually to the House and Senate Committees on Veterans' Affairs an updated 5-year plan for the construction, replacement, or modernization of medical facilities, including a priority listing of the 10 hospitals most in need of construction or replacement. No funds may be appropriated without both committees adopting a resolution authorizing the projects.

In addition, the GAO issued a report on September 20, 1982, on less costly alternatives for constructing new nursing homes. We will have a witness from the GAO give us the present status of this report and the one submitted to the subcommittee on December 30, 1981.

I am certain you all recall our April 1, 1982, hearing on the medical construction program when we learned of the revalidation of construction projects in the 5-year plan required by law. This revalidation was to be for those projects scheduled for fiscal year 1984 and the out years. At that time Mr. Nimmo said we would have the results of this process "by August or September, or perhaps earlier." The results have not been received as yet. However, we will be anxious to hear more about the revalidation.

In regard to revalidation, it is my recollection that the Inspector General triggered this process through his audit team recommendations. Mr. Daschle, the gentleman from South Dakota, brought this out very clearly in the April 1, 1982 hearing. Time did not permit Mr. Daschle to completely pursue the issue. I hope he will be afforded sufficient time this morning to complete his line of questioning this morning. The points Congressman Daschle was getting to were most pertinent to the escalation of costs and the untenable position placed on the medical construction program.

We also intend to discuss the 5-year construction plan for fiscal years 1983 through 1987, which was received by the committee in June 1982. There are several projects in this plan about which the subcommittee has questions. The replacement hospital in Minneapolis, Minn., is a good example.

Before we proceed with the first witness, I would like to say a few things about my esteemed colleague, the gentleman from Arkansas, the Honorable John Paul Hammerschmidt.

I want to take this opportunity, even though Mr. Hammerschmidt isn't here, and for the record, to thank him for all of his assistance on veterans' affairs through the years I have been a member of the committee. He has been truly a leader and a driving force in the development and implementation of programs for the American veteran. His leadership has also been a hallmark in making the Committee on Veterans' Affairs the most bipartisan committee in Congress. Without his leadership, much of the progress we have made would not have been possible.

Leaving this kind of leadership and good personal friends is not easy, such as my colleagues here this morning, like Mr. Edgar, Mr. Daschle, and Mr. Hillis. Knowing that Mr. Hammerschmidt and my colleagues that I just mentioned will continue as members of this subcommittee and the full committee is assurance to the people of this great Nation and to the veterans that their affairs are not just in good hands, but in great hands.

This morning we will have some distinguished guests. First of all, is Mr. Nelson here from Florida? If not, we will proceed with Robert A. Peterson, Senior Associate Director, Human Resources Division, General Accounting Office.

Mr. Peterson, welcome this morning. We look forward to your testimony. Without objection, your entire statement will be submitted into the record in its entirety. Hearing none, it will be so submitted.

You may proceed as you deem fit, to summarize or however you may want to proceed. Welcome here this morning.

STATEMENT OF ROBERT A. PETERSON, SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY NORMAN RABKIN

Mr. PETERSON. Thank you, Mr. Chairman.

Before I begin I would like to introduce Mr. Norman Rabkin on my right, who was the leader on the two studies that you referred to in your opening remarks.

Mr. MOTTL. Welcome.

Mr. PETERSON. Mr. Chairman and members of the subcommittee, I am pleased to be here this morning to discuss the medical construction program of the Veterans' Administration.

In October 1981, we reported that the VA had not been effectively planning and coordinating the construction or use of VA, State home, and community nursing homes. We concluded that VA and State home facilities may be built in areas having too many community or State nursing home beds, while not enough beds may be available in other areas to meet VA's anticipated needs. We recommended that the Administrator establish, in coordination with State and local health planning agencies, and the National Association of State Veterans' Homes, more realistic medical district plans for the construction and/or use of VA, community, and State nursing homes to provide care to veterans.

We reiterated and expanded on that recommendation in our September 1982 report to the Administrator which concluded that VA did not adequately consider local conditions or less costly alternatives before building new nursing homes.

We were concerned that VA's revalidation of construction projects recommended by the Administrator in February 1982 was not going to critically review the criteria VA had been using to justify nursing home construction projects. We were also aware of VA's move to decentralized planning and were concerned that the districts' continued reliance on VA's existing criteria could result in an unnecessarily expensive response to projected veterans' nursing home care needs, with oversupplies of nursing home beds in some geographical areas and shortages in others. We recommended that the Administrator insure that VA nursing home construction projects be proposed to the Congress only after a thorough consideration of less costly options.

In December 1981 we reported to this subcommittee about an opportunity to reduce the time VA takes to complete medical facility construction projects, thus minimizing the effects of inflation on overall project costs. At your request, we reviewed the reasons for cost growth in VA's medical facility construction program, the reason for large numbers of changes to design and construction contracts, and the cost these changes added to projects. We reviewed several recently completed projects—hospitals, nursing homes, and research and education buildings. We identified changes during the design phase which increased the projects' cost by 18.8 percent and changes made while the projects were under construction which added 6.9 percent to the construction contracts.

The time it takes to complete medical facility construction projects could be reduced by up to 15 months by extending the advanced planning fund to allow VA to contract for final design while the Congress reviews the projects. This could reduce overall project costs by minimizing the effects of inflation. However, there would be the added risk that, if the Congress did not approve or fund a project so designed, the final design cost could be wasted. Whether the changes should be made rests largely on the confidence the Congress has in the VA's ability to identify and prioritize its construction requirements.

In May 1977, we recommended that VA adopt a computer-based model which we had developed to determine the acute care bed needs of new and replacement hospitals. The basic problem had been that VA's health care system had centered around the acute care hospital. Because VA's former planning model relied on past experience in determining what was needed, estimates of hospital size tended to reflect the inefficient system of the past. Moreover, VA's planning model did not recognize in a precise way expected changes in the size and age mix of the veteran population.

We developed a new model which analyzed past practices and determined what different degrees of care should have been provided. Application of this model to projected veterans' population data showed that a mix of medical facilities different from that proposed in 1976 was needed to permit new replacement hospitals to have a range of health care options consistent with modern medical practice.

Since then VA has used the model and we have been working closely with the VA to improve the current model and expand its capability.

In March 1981 we reported that VA's criteria for surgical facilities in new or replacement hospitals was resulting in too many costly operating rooms. We noted that VA guidelines failed to consider that some occupants of surgical beds do not undergo surgery, and the time needed to perform a surgical procedure varied according to the type of surgery and the medical center. While the VA disagreed with some of the specifics in our report, it agreed to develop a new model similar to the one we proposed.

We have one audit currently underway which is addressing the growing disparity between the cost of constructing VA and community nursing home beds. The four nursing home construction projects approved in VA's fiscal year 1983 budget will provide 360 beds at a cost of about $35.5 million, or about $98,500 per bed. Community nursing homes are reportedly being constructed for under $30,000 per bed. Our initial objectives, therefore, are to more accurately determine the cost of constructing VA and community nursing homes and then to isolate specific items which cause the VA beds to be so much more expensive.

Mr. Chairman, this completes my statement. We would be happy to answer any questions you may have.

[The prepared statement of Mr. Peterson appears on p. 61.]

Mr. MOTTL. Thank you very much, Mr. Peterson, for the fine job you have done here this morning in your opening presentation. I want to commend you for your report bringing some of the shortcomings of the construction program to the attention of this subcommittee and to the entire Congress.

We will invoke the 5-minute rule because we have a good attendance here this morning. I will try to recognize the Members on both sides in the order that they came in.

Mr. Peterson, your study submitted to us on December 30, 1981, indicated the VA construction projects could be reduced up to 15 months by extending the advanced planning fund through the final design of a project. Can you elaborate on this for us, and how will this cut the time of the project by up to 15 months?

Mr. PETERSON. Yes, sir, I would be happy to.

As it works now, the advanced planning fund is used for preliminary design, at the end of which the VA should have a pretty good idea of the scope, complexity, and cost of the project that it is proposing. It then submits that project to the Congress for authorization. It is not until the Congress has decided whether it wants to go forward with that project that the final designs are contracted for. That process can take up to 15 months before you go from preliminary design into final design.

Our notion was that if the Congress was confident in VA's ability to identify and prioritize its needs, the advanced planning fund could be used to go into the final design while the Congress considers the merits of the project, much as, I might add, the Corps of Engineers does at the present time. That would shorten the overall project length by about 15 months. At the time we were looking at the projects, the inflation rate was about 11 percent in VA construction projects, so the 15 months comes out to about 13 or 14 percent of the cost.

Mr. MOTTL. Thank you very much.

Has any attempt been made to compare the costs of the VA nursing home construction with the VA approved nursing home projects at State veterans' homes?

Mr. PETERSON. We haven't done that specifically, although it is our understanding that the State homes do cost considerably less. We are looking right now at the difference between the actual costs of VA and community nursing homes.

I might add that VA's projections indicate that the cost of a VA nursing home bed is going to increase dramatically over the next several years. We have not specifically looked at the comparison between State homes and VA homes.

Mr. MOTTL. Could I make that request that you do make this comparison? I think it would be very helpful to the subcommittee.

Mr. PETERSON. I think we can do that in our survey without much problem.

Mr. MOTTL. Now, my last question. I have had a feeling that we can make a dramatic savings for the taxpayer with the change orders. I think in your report you say about 7 percent of the cost increase is due to change orders.

Do you have some proposals to this subcommittee that either we can induce some legislative initiatives or that we could have the

VA perform some administrative function where we can reduce the amount of change orders? Because that is not subject to competitive bidding. Once the contractor gives his lowest and best bid, he gets the contract for the hospital. So when there are change orders initiated, again at that point we don't have competitive bidding. So I think that is the time when the taxpayers could be ripped off.

Do you have any suggestions in this area, Mr. Peterson.

Mr. PETERSON. I think you have put your finger right on the problem, that change orders are not competitively bid, and then you have some problem in necessarily getting the best price for what you want done.

The change orders occurred in two phases in the facilities we looked at. There were changes in the design phase which increased both the cost of the design contract as well as the construction contract, and also ultimately affected the total cost of the project. Then there was the 7 percent that you mentioned that were made during the construction phase, that increased the project cost.

GAO, I guess, has been looking at change orders for a long time, and we have not come up with any panacea to solve that problem. If I had one thing to offer—the Department of Medicine and Surgery is involved in the VA construction program right through to the end. If I had an administrative recommendation, it would be to make sure that the changes initiated by the Department of Medicine and Surgery, especially during the construction phase, were really medically necessary, as opposed to a nice-to-have type change to the project, and try and get some discipline in the process so that early on the project would become fixed and there would have to be some very compelling reason to issue a change order. That's about the best I can do, I'm afraid, in terms of recommendations.

Mr. MOTTL. I think also, before I conclude my questioning here, if the GAO could come up with other recommendations besides the one you just suggested, I think it would be constructive. I think this is an area where we really have to work, whether it be by legislative initiative by this subcommittee or whether it has to be a VA initiative as far as administrative procedures. I think we really could do the taxpayers a great service by instituting some changes in this area and make some substantial savings.

The Chair would recognize at this time the gentleman from Indiana, Mr. Hillis, for any questions of Mr. Peterson.

Mr. HILLIS. Thank you, Mr. Chairman. I just have a couple.

In keeping with one of the questions which the Chair asked, Mr. Peterson, I would like to ask this question which the staff has prepared:

Why is the cost of construction of nursing beds gone up so dramatically as compared to the private sector? Does the VA have plans to reduce its costs? What's the problem in this area?

Mr. PETERSON. That is the problem we are currently addressing, Mr. Hillis. I think there are a number of reasons. We have not yet done enough work to be able to come forth and say these things are going to fix it.

The VA has been looking at the cost of nursing homes. Their project team has made recommendations, some 50-odd separate recommendations for reducing the cost of nursing homes. Many of them have been adopted that, to the best of my understanding, may reduce the cost of a 120-bed nursing home by about 20 percent.

There are a number of Federal requirements that may have some bearing on the cost. I would ask Mr. Rabkin if he could provide some more specifics on that.

Mr. **Rabkin**. VA has a couple of policies that they follow that tend to in some cases increase the cost of constructing nursing homes. For example, it is VA policy that all of the nursing homes be located on the grounds of the medical center adjacent to the hospital. Private industry sometimes builds nursing homes in areas that are not adjacent to hospitals and this gives private industry more flexibility in selecting a site where the preparation costs would not be high. In some cases, VA spends over $1 million in just preparing the site, as opposed to selecting a site that is off the grounds of the medical center that would not need such extensive work. So that tends to increase the cost.

As Mr. Peterson said, the so-called Federal presence, the number of Federal laws affecting Federal construction, tends to inflate the cost of the Federal nursing homes as opposed to the private nursing home.

Mr. **Hillis**. I would yield to Mr. Dunn for a question.

Mr. **Dunn**. Is Davis-Bacon one of those costs?

Mr. **Peterson**. Yes, sir, it is.

Mr. **Dunn**. About what percent?

Mr. **Peterson**. I don't have that figure readily available.

Mr. **Rabkin**. There are a number of studies that try to identify the amount of increase that is due to the Davis-Bacon Act. We haven't found any that specifically relate to nursing homes, so we just can't answer that.

Mr. **Hillis**. Could I ask you for the record, if you would submit an itemization of those costs, not only Davis-Bacon—I am interested in that—but other Federal laws and requirements that cause an increasing cost in your opinion over the private sector so the committee can analyze them and see what might be able to be done.

Mr. **Peterson**. We would be happy to give you those that we can identify at this point in time, recognizing that our work is ongoing and perhaps as that moves forward we will be able to give a much fuller picture of what the cost differences are.

[The following was subsequently submitted for the record.]

GAO and several other organizations have conducted studies to determine the differences between the Federal and private construction costs. While Federal construction costs generally are higher than similar private construction, the impact of Federal laws and regulations on construction costs is difficult to quantify with any degree of accuracy. Nonetheless, Federal laws and regulations have significant cost implications which are peculiar to Federal construction and are generally not applicable to private construction.

During past reviews, we examined specific legislation, policies, procedures, requirements, and restrictions imposed on Federal construction. Although the following list may not be all-inclusive, some of the most noticeable contractual requirements that contribute to the higher cost of Federal construction are:

Restrictive procurement policies.—Buy American Act (41 U.S.C. 10a-10d) requires contractors to purchase certain domestic construction materials. Federal Procurement Regulations require that contracting agencies not identify manufacturers or trade names in specifications.

Affirmative action.—Small Business Act (15 U.S.C. 631 et seq.) requires contractors to use firms owned and controlled by socially and economically disadvantaged individuals when possible, and submit periodic reports and cooperate in any studies or surveys as may be required by the contracting agency. The act also requires Federal agencies to award a percentage of their total construction contracts to small and minority businesses.

Labor standards.—Davis-Bacon Act (40 U.S.C. 276a–276a-7), Copeland Anti-Kickback Act (18 U.S.C. 874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. 327–330) require contractors to file weekly payroll reports listing for each employee the hours worked, wage rate, total earnings, deductions and net pay as well as statistics on minority employment. The Davis-Bacon Act generally results in higher wage rates on Federal construction, particularly in nonmetropolitan areas of the country.

Mr. HILLIS. Thank you.

That's all the questions I have.

Mr. MOTTL. Thank you very much, Mr. Hillis.

The Chair would like to thank you for your invaluable contributions to the subcommittee through my chairmanship. You have done a great job for us, Mr. Hillis. Thank you very much.

Mr. HILLIS. Mr. Chairman, I thank you for those nice words. It has been such a pleasure for all of us to work with you. We couldn't have had a better chairman. I think the accomplishments of the committee—it has been a very nonpartisan committee under your leadership and we thank you very much.

Mr. MOTTL. Thank you very much for those kind remarks, Mr. Hillis.

Next we will recognize the gentleman from Pennsylvania, a good friend of mine, who has done a great job on the Education Subcommittee. It is my understanding he is going to take over this important subcommittee. I am sure his contributions are going to be great and I am sure the 98th Congress looks forward to your leadership on this subcommittee.

Mr. EDGAR. Thank you, Mr. Chairman.

I just have a couple of questions to ask relating to your statement.

You mentioned on page 3 of your statement that the VA has moved to decentralized planning, and you mention that you are concerned that the districts continued reliance on VA's existing criteria could result in an unnecessarily expensive response to projected veterans' nursing home care needs.

I am not exactly sure I understand the comment there. It seems on the one hand that giving a local region or area the opportunity to do some direct impact in the construction of the facilities saves money, and yet you raise a concern there on page 3.

Mr. PETERSON. Our concern is really with the national criteria that VA uses. In the nursing home arena, the VA has essentially decided that 20 percent was its market share for providing nursing home care beds to veterans, that it will serve 20 percent of the veteran population. That has been subdivided, 40 percent of that need will be met in VA facilities, 40 percent in community facilities, and 20 percent in State veteran homes.

Those criteria don't necessarily match up with the situation in a local area. Some places don't have any State homes; some places have an abundance of community nursing homes, and some don't. We are concerned, have been concerned, that the application of the national criteria to local situations, medical districts, and the medical centers' service areas, can result in some distortions and result in oversupplies and undersupplies unless those are, in fact, geared to the local situation.

Mr. EDGAR. Are you requesting more flexibility at the local level, or less?

Mr. PETERSON. I think we're requesting a lot more flexibility at the local level.

Mr. EDGAR. And have you made any recommendations as to how that would be administered?

Mr. PETERSON. We did make recommendations to the Administrator in September of this year, that the local conditions be considered, not only in terms of the availability of community nursing homes but in terms of the possibility of changing the mission of existing facilities, to use available space and have VA facilities converted into nursing homes before you go ahead and build new nursing homes.

Mr. EDGAR. Let me draw your attention to page 5 where you talk about the fact that in May 1977 you recommended that the VA adopt a computer-based model which you developed to determine the acute care bed needs of new and replacement hospitals.

It seems to me it is a good idea to have a computer model. How do you develop a computer model that takes into account those kinds of local flexible needs and, second, why has it taken so long for the computer model to be put in place and work? What are the changing things that are occurring that cause that computer model to not be effective and working now?

Mr. PETERSON. We are quite proud of the computer model. It has been used for quite some time now, both by the Department of Defense and the Veterans' Administration. It is in constant refinement.

The computer model does exactly what you are indicating it might not. It does consider the age-specific diagnoses and the workload at the individual medical center level, and it uses the professional activities study, if that's the correct term, which involves specific diagnosis by age and length-of-stay data. At the time we started this it involved some 13.2 million discharges in hospitals around the country. It applies those length-of-stay criteria to determine what the VA acute care bed needs are, taking into consideration very specific age and diagnosis workloads that they have at a particular medical center. So we think it is, and I think VA agrees, and so does the Department of Defense, that it does serve as a very useful tool in determining what the needs are in a specific geographic location.

Mr. EDGAR. Mr. Chairman, I have one final question.

Mr. MOTTL. Go ahead.

Mr. EDGAR. Given all the background that the two of you have in overseeing and looking at the VA's construction process, in a nutshell what would be the one recommendation you would make if you had either a magic wand to wave or some administrative authority to say to the VA "Here are the specific changes we would like to see you make in your process"? What is the key or core of that nutshell that you would suggest?

Mr. PETERSON. That's an extremely difficult one. I think there are a number of issues that have sort of not been addressed head on, and that has to do with who is the VA going to serve. That involves questions as to what kind of capacity are you going to be building into the system to deal with nonservice-connected veterans as opposed to those who have some service-connected disability. I think that is a key question as to what the system ultimately should look like. Who are you going to serve?

I would ask Mr. Rabkin if he can make a comment.

Mr. **Rabkin**. Again, it is difficult to just pick out one. But I would suggest the VA and Congress consider the length of time that the facilities are going to be needed and whether the VA should, for example, be building a nursing home that will last 50 or 60 years when the peak demand is going to be within the next 20 to 30 years, and whether VA is considering alternative uses of those nursing homes after the peak or alternative ways of providing the beds that they need now without having to construct a facility that will last 50 years.

Mr. **Edgar**. I would just close by asking you perhaps to submit by letter a list of the four, five, six or seven specific recommendations that you would make, given all of the data and all of the reviews that you have made, just so they can be very clear.

Mr. **Peterson**. We would be happy to do that.

[The following was subsequently submitted for the record:]

VA's Construction Process: Issues for Consideration

In prior reports, GAO has recommended improvements in VA's construction process. VA has implemented many of these recommendations. Listed in Attachment I are several recommendations which VA or the Congress have not completely implemented.

GAO ongoing audit work has not progressed far enough for us to offer additional specific recommendations for improving VA's construction process. However, we have identified a number of issues which the Subcommittee may wish to pursue with VA during the 98th Congress. These are discussed in Attachment II.

[ATTACHMENT I]

VA's Construction Process: GAO Recommendations From Prior Reports

TARGET POPULATION

In 1977 and 1978 we issued several repoets to the Chairman, Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations, concerning VA's methodology for determining the number of beds needed in repleacment hospitals. In our first report (HRD-77-104, May 20, 1977) we recommended that the Congress explore to what extent VA hospitals authorized in the future should have the capacity available to provide for the treatment of veterans with nonservice-connected illnesses. We pointed out that the replacement hospital at the VA medical center in Richmond, Va. was being planned for 700 beds. We calculated, based on our bed sizing model, that if the hospital were planned to treat veterans only for their service-connected disabilities, it would only need 74 beds. If the hospital were planned to treat service-connected veterans for either service-connected or nonservice-connected disabilities, it would only need 114 beds. If the hospital were planned to treat the same mix of service-connected and nonservice-connected veterans as it has in the past, it would need 620 beds.

OPERATING ROOMS

In March 1981, we reported that VA's criteria for surgical facilities in new or replacement hospitals was resulting in too many costly operating rooms. ("Better Guidlines Could Reduce VA's Planned Construction of Costly Operating Rooms," HRD-81-54, May 3, 1981.) We noted that the VA guidelines failed to consider that many occupants of surgical beds do not undergo surgery, and the time needed to perform a surgical procedure varied according to the type of surgery and the surgeon's experience. VA disagreed with some of the specifics of our report but agreed to develop a new model, similar to the one we proposed. We also recommended that VA develop better staffing guidelines for operating room nurses and better use these nurses by assigning nonprofessional tasks to less skilled personnel. VA reports that it is in the process of implementing these recommendations.

VA SUPPORT OF STATE VETERANS' HOMES CONSTRUCTION PROJECTS

In October 1981 we reported that VA had not been effectively planning and coordinating the construction or use of VA, State home, and contract community nursing homes. ("State Veterans' Homes: Opportunities to Reduce VA and State Cost and Improve Program Management," HRD-82-7, Oct. 22, 1981.) We concluded that VA and State home facilities may be built in areas having too many community or State nursing home beds, while not enough beds may be available in other areas to meet VA's anticipated needs. We recommended that the Administrator establish, in coordination with State and local health planning agencies and the National Association of State Veterans Homes, more realistic medical district plans for the construction and/or use of VA, community and State nursing homes to provide care to veterans. We also recommended that VA determine the need for each State home construction project before approving funding for its construction. VA agreed to implement both of the recommendations through its Medical District Initiated Program Planning (MEDIPP) process.

ADVANCED PLANNING FUND

In December 1981 we reported to this Subcommittee about an opportunity to reduce the time VA takes to complete medical facility construction projects, thus minimizing the effects of inflation on overall project costs. ("Opportunity to Reduce the Cost of Building VA Medical Facilities," HRD-82-28, Dec. 30, 1981.) At the Subcommittee's request, we reviewed the reasons for cost growth in VA's medical facility construction program, the reason for large numbers of changes to design and construction contracts, and the cost these changes added to projects.

The time it takes to complete medical facility construction projects could be reduced by up to 15 months by extending the Advanced Planning Fund to allow VA to contract for final design while the Congress reviews the projects. This could reduce overall project costs by minimizing the effects of inflation; however, there would be the added risk that, if the Congress did not approve or fund a project so designed, the final design costs could be wasted. Whether the changes should be made rests largely on the confidence the Congress has in VA's ability to identify and prioritize its construction requirements. VA has testified that it is considering recommending legislative change to implement this recommendation.

NURSING HOME CONSTRUCTION PROJECTS

In a September 1982 report to the Administrator we concluded that VA did not adequately consider local conditions or less costly alternatives before building new nursing homes. ("VA Should Consider Less Costly Alternatives Before Constructing New Nursing Homes," HRD-82-114, Sept. 30, 1982.) Specifically, we found that VA:

Justified new nursing home construction using national demographic and needs projections with little input about the characteristics and resources of the medical districts or the medical centers' primary service areas;

Did not adequately consider the option of providing more nursing home care in community nursing homes by expanding its use of existing legislative authority to contract for care; and

Did not adequately consider converting, renovating, or changing the mission of existing VA facilities to help meet the need for more nursing home beds.

We were concerned that VA's revalidation of construction projects, recommended by the Administrator in February 1982, was not going to critically review the criteria VA had been using to justify nursing home construction projects. We were also aware of VA's move to decentralized planning (MEDIPP) and were concerned that the districts' continued reliance on VA's existing criteria could result in an unnecessarily expensive response to projected veterans' nursing home care needs, with oversupplies of nursing home beds in some geographical areas and shortages in others. We recommended that the Administrator ensure that VA nursing home construction projects be proposed to the Congress only after a thorough consideration of less costly options. The Administrator has agreed to improve VA's planning process.

[ATTACHMENT II]

VA's CONSTRUCTION PROCESS: OTHER ISSUES FOR CONSIDERATION

MEDIPP

MEDIPP, or medical district initiated program planning, is a "grass-roots" strategic planning system, being relied on to establish the future direction of VA's Department of Medicine and Surgery. The Subcommittee may wish to monitor the process by which the districts and central office will be selecting and justifying construction projects, especially (1) the extent to which missions of specific VA medical centers are redefined and (2) VA's success in identifying facilities where space can be converted or renovated to avoid costly construction.

LONGER RANGE PLANNING

Although it will be an on-going process, MEDIPP initially will only plan through 1990. Considering the age of many of VA's hospitals—69 of the 172 in VA's system were built before 1930—and that it takes several years to plan, design, and construct a medical facility, the Subcommittee may wish to consider whether VA has adequate long-range plans for replacing its older facilities.

SHARING OF MEDICAL RESOURCES

Recent legislation (Public Law 97-174) encourages and provides the framework for greater sharing of health care resources between VA and the Department of Defense. The Subcommittee should ensure that VA has considered sharing opportunities before building new facilities, replacing existing facilities or expanding medical services.

OPTIMUM USE OF COMMUNITY RESOURCES

VA relies on non-Federal health care resources to provide medical and dental care on a fee-basis to veterans who do not live near a VA hospital or clinic, or who need specialized treatment not available at a nearby VA facility. VA also uses sharing agreements with affiliated hospitals and medical schools, contracts with community nursing homes, and provides construction and per diem support to State veterans' homes instead of providing additional services in its own facilities. The Subcommittee may wish to consider whether VA has adequately considered the availability of non-Federal resources when it justified construction projects.

PRIORITIZATION OF CONSTRUCTION PROJECTS

VA is required by 38 U.S.C. 5007 to present a five-year plan of its medical facility construction needs and a list, in order of priority, of not less than ten hospitals most in need of construction or replacement. In a recent letter to the Chairman, Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations, VA explained the primary and secondary factors it considers in assessing the relative deficiencies and needs of potential construction projects. Because it is generally recognized that VA construction budgets will never be large enough to support all of the projects proposed by the medical centers and districts, the Subcommittee might want to consider how VA has been applying those factors and assessing the relative priority of proposed construction projects.

ROLE OF THE INSPECTOR GENERAL IN VALIDATING JUSTIFICATIONS FOR CONSTRUCTION PROJECTS

VA's Office of Inspector General has issued several reports on specific construction projects at individual VA medical centers, as well as on VA's construction process in general. Many of these reports have identified projects which in the Inspector General's opinion, were overplanned and could have been cancelled or reduced in scope, resulting in significant savings. It was partly becasue of these Inspector General reports that the Administrator ordered a revalidation of all major construction projects proposed for funding in fiscal year 1984 and beyond. The Subcommittee may wish to consider (1) the extent to which these Inspector General reports are used by VA in proposing construction projects, and (2) whether the Inspector General should routinely review and validate justifications for major construction projects.

PROBLEMS WITH VA'S AUTOMATED INFORMATION SYSTEM

VA justifies projects for new and replacement facilities by projecting the use that veterans will make of them. These projections are based on data gathered, analyzed, and reported through two information systems: VA's Automated Management Information System (AMIS) and its Patient Treatment File (PTF). As we and VA's Inspector General have reported, the data produced by these systems are generally not reliable. VA is working on several projects to improve these systems. In the meantime, the Subcommittee may wish to consider the extent to which individual construction projects rely on data from these systems for their justification and whether the data are reliable enough to support the projects.

VA'S METHODOLOGY FOR PROJECTING WORKLOADS

As part of the MEDIPP process, DM&S has provided medical districts with a general methodology for assessing veterans' future health care needs and determining what portion of those needs should be met through VA health care programs and in VA medical facilities. The methodology relies to a great deal on historical data (and is subject to the reliability problems mentioned above) but also allows for independent assumptions by the planners. The Subcommittee might want to consider (1) whether VA's methodology gives sufficient consideration to demographic factors such as the aging of veterans population and migration of veterans to warmer climates, and (2) if VA is adequately monitoring the independent assumptions being made by district planners.

DM&S'S ROLE IN THE DESIGN AND CONSTRUCTION OF MEDICAL FACILITIES

The Department of Medicine and Surgery is responsible for identifying what medical facilities need to be built or remodeled; the Office of Construction is responsible for getting them built or remodeled. However, VA's construction process allows (and encourages) DM&S officials at the medical center and central office to stay involved in the project even after it is planned. As we pointed out in our December 30, 1981, report to this Subcommittee, most changes to design and construction contracts were made to incorporate DM&S requests to alter the medical features of the facility. The Subcommittee may wish to explore with VA ways to insure that changes made by DM&S during final design and construction are essential.

MEDICAL CENTER MANAGEMENT OF CONSTRUCTION PROJECTS

VA's Office of Construction generally manages all major construction projects. However, the House Appropriations Committee recommended that three nursing home construction projects, funded in fiscal year 1982, be managed by the hospital directors rather than the Office of Construction. The Subcommittee may wish to monitor these projects and explore with VA whether they are being completed more or less efficiently and economically as projects managed by the Office of Construction.

Mr. **Edgar**. Thank you for your testimony this morning.

Mr. **Mottl**. Thank you very much, Mr. Edgar. And the Chair would like to thank you for your invaluable contributions to this committee. You have been just outstanding.

The gentleman from Florida, who has done a great job for making the subcommittee aware of the additional need for medical facilities in that great State. The Chair would recognize Mr. Mica.

Mr. **Mica**. Thank you, Mr. Chairman.

Before I start, let me just say that we all continue to thank you for giving us the opportunity in having these hearings. They have been important to all of us, to this Nation and to my own State. It has been very, very helpful.

Mr. Edgar has touched on most of the areas that I wanted to touch on, but I would like to make it clear on the record that you are talking about justifying new nursing home construction using rather localized demographics rather than the old procedures of national demographics; is that correct?

Mr. **Peterson**. Yes, sir.

Mr. **Mica**. In other words, what you are saying is that in places like Florida, where the average veteran is 62.6 years old moving into the State, that that ought to be considered; is that correct?

Mr. **Peterson**. I would think so; yes, sir.

Mr. **Mica**. What you're saying, too, then, is when someone is over the age of 65, according to the home care statistics given by the Veterans' Administration, they need approximately 4 times more care than those under 65; is that correct?

Mr. **Peterson**. I don't know if those figures—I assume those figures are correct. I do know that the older you get, the length of stay goes up——

Mr. **Mottl**. Mr. Mica, are these leading questions?

[Laughter.]

Mr. **Mica**. Yes, they are. The point that I'm trying to make, you are very definitely saying that we need to consider these figures, maybe not in this hearing. But, for one, I would like to come back and refer to this record and say if you have 1 veteran or 10 veterans or 100 or 1,000 veterans in one State, and 1,000 in another, the demographics may be quite different, but it doesn't mean the needs are the same; the needs will be different.

I would like to point out what Mr. Edgar said—I do have some concerns on the first page where you say we need to make sure all the local needs and demographics are considered, and then go back to the discussion of the national computer model. That's fine and that's very important. But, I want to make sure that that computer model is set up in a way that looks at the local demographics, State demographics; otherwise, we're right back to the situation we're trying to avert.

Now, one other point. On the changing of the mission of existing VA facilities, can you tell me—you mentioned changing beds in acute care hospitals to nursing homes, is that correct?

Mr. **Peterson**. Yes, sir.

Mr. **Mica**. What other areas are you trying to——

Mr. **Peterson**. Well, we haven't tried to do a complete census, but there are a number of cases where the acute care facility, the character, because of the demographics, the age changes and so forth, the type of medical care to be delivered at a facility changes over time. Very often in an acute care facility you will have vacant or underutilized beds that can be converted to some other use, long-term care beds in particular.

Mr. **Mica**. Are you talking about tangible conversions strictly, or would you also be referring to staff or the staff ratio? For instance, if you have a hospital in the Midwest where the veterans' population would not be known, and a hospital in a Sun Belt State has had a tremendous growth, and the staff ratio to patient ratio and so on has been altered dramatically, wouldn't it be appropriate under your testimony and your feelings here to say the ratios ought to be switched?

Mr. **Peterson**. I would say all of those things would have to be considered, yes, sir.

Mr. **Mica**. You said facilities, and I just wondered if you were getting into considering that part.

Mr. **Peterson**. We haven't specifically addressed that part, but what you say doesn't cause us any problem. I think we would expect that if the character of the medical care was changing, the character of the medical staff would have to keep pace with that.

Mr. MICA. Now, this is just a point of personal information.

You are talking about reducing by some 15 months the advanced planning time for hospital construction, since we have some cooperation between the Congress and the VA; is that correct?

Mr. PETERSON. That's correct.

Mr. MICA. You are saying that this would be based largely on the confidence the Congress has in the VA. My feeling is that confidence would be greatly enhanced as long as there is close cooperation. I think what I have seen the members balk at is the situation where any agency comes in and tells the committee "this is what we're going to do, and if you don't support it we lose all our funding." I think close cooperation is important.

Mr. Chairman, I see that my time is up. If I could have 30 additional seconds.

Mr. MOTTL. You may.

Mr. MICA. I just would like to know, on this 15 month reduction in time, what would it take, under normal circumstances, to construct a new hospital from start to finish if we were able to eliminate 15 months?

Mr. PETERSON. I have to go back and look at our data. The bigger the project, of course, the longer it takes. Some of them take several years to construct.

Mr. MICA. I would like to get some kind of a ball park figure, as close as you can.

Mr. PETERSON. Mr. Rabkin has fished out our data and will comment on that.

Mr. RABKIN. Of course, it varies per hospital. Generally, the range is, from the time the first appropriation is made until the hospital is completed, the ones that we looked at, is anywhere from 4 to 8 years.

Mr. MICA. Anywhere from 4 to 8 years?

Mr. RABKIN. Yes.

Mr. MICA. Thank you, Mr. Chairman.

Mr. MOTTL. Thank you very much, Mr. Mica. Again, we want to thank you for your many contributions to the subcommittee. You have been a great member.

Next I would like to recognize my distinguished colleague from Ohio, a long-time friend and colleague who has made many contributions to the subcommittee, Mr. Applegate.

Mr. APPLEGATE. I have no questions, Mr. Chairman.

Mr. MOTTL. Thank you very much, Mr. Applegate. We want to thank you, though, for your contributions. You have been an outstanding member and we really appreciate your contributions.

Mr. Peterson, we want to thank you for the outstanding job that you have done here this morning. We would be hopeful—and I am sure Mr. Edgar would also associate himself with these suggestions—that we can work very closely with you, and the 98th Congress has to work very closely with this subcommittee, because we want to do something constructive, to make sure that the taxpayer isn't going to be ripped off in hospital construction. I think you have come up with some outstanding suggestions for the subcommittee, but we would like you to elaborate on those, if you would, please, and submit those in writing to Mr. Edgar, if you would.

Mr. PETERSON. We would be happy to do that.

Mr. MOTTL. The Chair thanks both of you this morning for your great job.

Mr. PETERSON. Thank you.

Mr. MOTTL. I see in the audience an outstanding friend of ours, the Congressman from Minnesota, Bill Frenzel. Bill, would you come forward? I know your time is valuable and you have got other things to do this morning. The subcommittee looks forward to your statement, and your entire statement will be submitted into the record without objection.

Not only is Minnesota very fortunate to have someone of your caliber representing them, but the entire country. You have been an outstanding Congressman serving very well here in the House of Representatives, not only in the House itself but also on the playing field as a great catcher for the Republicans. So the Chair would certainly welcome you here on behalf of the subcommittee and we look forward to your statement. You may summarize it or read it in its entirity, however you deem fit.

STATEMENT OF HON. BILL FRENZEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. FRENZEL. Thank you very much, Mr. Chairman, and members of the committee. I will summarize.

But before I begin, I want to say how much we are going to miss you, Mr. Chairman, not just the veterans, not just your friends in Congress, but all of the people of the United States whom you have served so well. We wish you would continue to be with us, but since you aren't going to be, we wish you well in whatever you do.

Mr. MOTTL. Thanks very much, Bill.

Mr. FRENZEL. Mr. Chairman, I don't want to take too much of the committee's time. The reason that I am here is, again, the Minneapolis Veterans' Hospital. There have been persistent rumors and attempts by OMB to reduce the size of that hospital. Two years ago, this House and this Congress decided on the size, when an amendment was raised on the floor to reduce the size of the hospital. The House voted overwhelmingly in favor and the Senate voted overwhelmingly in favor of the design size which, as indicated in my testimony, was 725 acute beds and 120 nursing home beds.

At the time, the reason that amendment was made was because of the Metropolitan Health Board's suggestion that the hospital be reduced in size. Now, as I understand it, OMB is saying again that the hospital should be reduced in size.

Mr. Chairman, at that time the House determined that service to veterans was quite different from service in the other hospitals in the area. The service area of the veterans' hospital extends over five States, and the Metropolitan Health Board's jurisdiction extends over seven counties. It is two different kinds of health systems.

Congress of the United States,
House of Representatives,
Washington, D.C., December 13, 1982.

Hon. Ronald M. Mottl,
Chairman, Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs.

Dear Mr. Chairman: We remain concerned about the fate of the Minneapolis VA hospital, which serves the veterans we represent.

Although we believe the Veterans Administration, this Subcommittee and the full Committee, as well as its counterparts in the Senate, and the Appropriations Committees have all recognized the necessity for a replacement hospital in Minneapolis, we are concerned that the facility be authorized for construction in fiscal year 1984. Moreover, we believe that the hospital should be constructed in the size originally recommended. We believe that a new Veterans Hospital with less than 725 acute care beds could not adequately serve the aging and increasing veterans population in the Minneapolis VA hospital service area.

As you know, the Minneapolis hospital has faced numerous obstacles in the past. Nonetheless, we believe that it has now been established as the VA's number one building priority, a position it merits after being ranked as such by the Veterans Administration for several years. The antiquated, inadequate facility at Fort Snelling must be replaced if we are to continue our commitment to medical care for veterans.

We believe the hospital should, and will, be built. Our present concern is with the size of the hospital. The Minnesota Department of Veterans Affairs recently concluded that if Minnesota's elderly veterans are to receive the same service in 1990 and 2000 that they receive in the 1980's, the number of hospital beds in the service area will have to be increased by 754 beds by 1990 and 978 beds by 2000, if low demand is assumed. If high demand is assumed, more than 3,800 beds would be required. Obviously, the recommendation of 725 beds already makes heroic assumptions about the characteristics of the Minnesota veterans population. We believe any further reductions would seriously compromise veterans medical care.

Therefore, Mr. Chairman, we respectfully request that the Minneapolis VA replacement hospital be maintained as the highest priority VA construction project, and that it not be reduced below 725 acute care beds. We appreciate your careful consideration of this important matter.

Yours very truly,

Bill Frenzel, Arlan Stangeland, Vin Weber, Bruce Vento, Berkley Bedell, James L. Oberstar, Tom Hagedorn, Arlen Erdahl, Rudy Boschwitz, Dave Durenberger.

There is really some relationship, but the work is not totally correlated. So the Minnesota delegation and some of our friends from the other areas served by the hospital wanted simply to get back to you so that you would not be fooled by suggestions that the hospital should be reduced in size. The letter that we have submitted to you has been signed by seven Minnesota Congressmen, two Senators, and a few of the others. We really didn't have time to get the thing together in time to meet your meeting.

You will recall that in the House appropriation there was money this year for this hospital. The Senate decided not to put it in. But Senator Simpson, who chairs the committee of jurisdiction, and Senator Garn, who chairs the appropriations subcommittee of jurisdiction, have both indicated in floor statements that they would support it in the upcoming year's appropriation.

It is simply our hope that the hospital should go ahead as planned. We don't see any reason to change the size of the hospital. As you were assembling your list of priorities for the coming year, we wanted to be sure that there was no doubt in your mind that that hospital should go forward as you have planned and we have planned.

Mr. Chairman, I speak for my Minnesota colleagues and for those in the neighboring States who are served by that hospital. I thank you for your attention. I know you have a lot of work to do today.

[The prepared statement of Mr. Frenzel appears at p. 80.]

Mr. **Mottl**. Thank you very much.

I want to thank you for your outstanding contribution. I want to reassure you that we are still with you. We are going to have the VA representatives here following you and we will ask some pertinent questions on this issue.

Mr. **Edgar**. Mr. Chairman.

Mr. **Mottl**. Yes, Mr. Edgar.

Mr. **Edgar**. I would like to just take a moment to say that, based on the legislative history which you recounted dealing with this particular hospital, and the need in Minneapolis, this project will be a major concern of the medical subcommittee in the next Congress. As our chairman, who has been very diligent over the last 2 years in watching the affairs of the hospitals and the health care area, knows, it is a tough process, given all of the budget pressures that we face.

As I begin to assume the responsibility that he now has, I want you to know that we plan to keep an eye not only on the number of beds provided for in this hospital but the speed in which the hospital construction can move ahead, so that that facility can be used very quickly.

Mr. **Frenzel**. I greatly appreciate that, and I am glad to know that there will be a continuity of planning and a determination on this committee. Thank you, sir.

Mr. **Mottl**. Mr. Mica, did you have any questions of Mr. Frenzel?

Mr. **Mica**. No questions. I might just say to my colleague that we are going to do all we can to maintain the facility there, and also to make sure that any who choose to move to Florida will have adequate facilities there. [Laughter.]

Mr. **Frenzel**. Those fortunate enough to move to Florida I hope will find adequate facilities.

Mr. **Mottl**. Mr. Applegate, do you have any questions?

Mr. **Applegate**. I have no questions.

Mr. **Mottl**. Bill, an outstanding job. We appreciate your presence here this morning.

Mr. **Frenzel**. Thank you very much.

Mr. **Mottl**. Next the committee will hear from the Honorable Everett Alvarez, Jr., Deputy Administrator, Veterans' Administration. We want to welcome you and your entire staff to the committee hearing this morning.

Before you introduce your colleagues at the head table and proceed, your entire statement will be submitted into the record without objection.

We are all anxious to know how our dear friend, Dr. Donald Custis, is faring in the hospital. Could you give us a report, please, first of all?

Mr. **Alvarez**. Mr. Chairman, I would like to defer that to Dr. Bill Jacoby, our Deputy Chief Medical Director, who spoke with the staff at Bethesda Hospital this morning.

Mr. **Mottl**. Certainly.

Dr. **Jacoby**. Thank you, Mr. Alvarez.

Mr. Chairman, members of the committee, Dr. Custis, as you know, was admitted to the National Naval Medical Center in Bethesda on Sunday. He had an acute attack, for which he was evaluated at that hospital. He was admitted. He has had multiple diagnostic studies and they are ongoing at the present time. He is resting comfortably. The physicians who are caring for him are extremely satisfied with his progress to date. We are quite pleased with his progress report but we anticipate that he will be hospitalized for several weeks.

Mr. MOTTL. All right. Thank you very much.

Doctor, would you convey to him that we all miss him very much and that I, as the subcommittee chairman, just want to express my appreciation to him, because I think he is the finest Director or Chief we have ever had. I just hope that, on behalf of all veterans throughout this country, that he will be back on the job as soon as possible.

Dr. JACOBY. Thank you very much, Mr. Chairman. I will see that that message is conveyed to Dr. Custis.

Mr. MOTTL. Thank you.

Mr. Alvarez, would you proceed then?

STATEMENT OF EVERETT ALVAREZ, JR., DEPUTY ADMINISTRATOR OF VETERANS' AFFAIRS; ACCOMPANIED BY JOHN MURPHY, GENERAL COUNSEL; DR. WILLIAM JACOBY, DEPUTY CHIEF MEDICAL DIRECTOR; WILLIAM SULLIVAN, ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS; WILLIAM SALMOND, ASSISTANT DEPUTY ADMINISTRATOR, OFFICE OF CONSTRUCTION

Mr. ALVAREZ. Thank you, Mr. Chairman.

Before I proceed I would like to introduce my colleages at the table. On my far right is our General Counsel, Mr. John Murphy. On my immediate right is Dr. Bill Jacoby, who you just heard. On my immediate left is our Associate Deputy Administrator for Logistics, Bill Sullivan; and on my far left is our Assistant Deputy Administrator in charge of the Office of Construction, Mr. Bill Salmond.

Mr. Chairman and members of the subcommittee, I am pleased to appear before you this morning to discuss the Veterans' Administration's medical facility planning and construction program.

As you know, our proposed fiscal year 1984 construction request will soon be submitted to you for review. Since the budget has not been released yet, I cannot discuss the specifics of our proposal today. However, I am pleased to inform you that our request calls for the largest construction budget ever proposed by the Veterans' Administration.

Our fiscal year 1984 construction proposal reflects our continued and strong commitment to provide a modern, comprehensive and independent health care delivery system which meets the veterans' needs and, in particular, the needs of the aging veterans, and our statutory responsibilities.

The VA's health care facilities are aging and, in many instances, outdated. Improvements and alterations are necessary. In some cases, total replacement of these facilities will be more cost effective. To meet these construction needs and to provide the most comprehensive medical care, it is clear that increased resources will be required. As our new Administrator-designate reaffirmed last week at his confirmation hearing, the VA is the veterans' voice in Washington and we will serve as strong advocates for the resources necessary to meet their health care needs.

To assist us in planning for these resource requirements, we have in recent years initiated a number of significant improvements in our facility planning program. These improvements will help us to more effectively determine and rank our construction needs on a system-wide basis, and also to help us to more objectively develop the physical and program requirements necessary to meet the veteran health care needs. We expect these improvements will be on line in part for our fiscal year 1985 construction program and hope that they will fully be implemented in time for development of our fiscal year 1986 and outyear construction programs.

Pending full implementation of these planning refinements, the Administrator also initiated last year a special interim effort directed toward insuring that the major construction projects we were considering, and which were developed without the improved procedures we are now implementing were fully justified and based on accurate and defensible planning data. This review effort is now completed and we believe it was a productive process which not only re-emphasized the importance of quality controls in project developments, but also placed the agency in a better position to justify our major construction needs.

Our special construction program review this past year demonstrated that while our current project development process is basically sound, some procedural improvements could be made. We are now building on the beneficial lessons of this review and are incorporating these procedural refinements into our normal planning and project development system for use in developing our construction programs in the years ahead. As a result, it will not be necessary to repeat the type of special review we previously initiated; rather, the benefits of this special review will be integrated into our normal project development system to insure that project validation is emphasized as an ongoing and permanent part of our project planning and development procedures.

The results of our special project review just completed were that, of the 57 major construction projects on our review list, 35 projects were found ready for consideration, as currently planned, or with minor modifications. One nursing home project was canceled and resited to another nearby medical center because of the better site location. The remaining 21 projects simply were not ready for consideration either because of ongoing DM&S re-evaluations of the project or because of the status of the preliminary design plans.

The fact that there were originally 57 projects on our review list does not mean that all of these projects would have been considered had they not been reviewed, nor that those ultimately considered not yet ready are not good projects. In some cases, design plans were just not ready. In other cases, DM&S was re-evaluating the project in conjunction with the Medical District Initiated Program Planning, or MEDIPP, process. Indeed, 11 of the 21 projects which were not ready for consideration were not even in the 5-year plan for fiscal year 1984. We only included those projects on the outside chance that perhaps some could be readied in time. These projects will be considered in future years as their development is completed.

I would be pleased to provide for the record a list of the 57 projects assigned for review, a list of the 35 projects found ready for consideration, and a list of the projects which were determined not ready for fiscal year 1984 consideration and the reasons why.[1]

Mr. Chairman, before concluding my statement I also would like to join your colleagues in commending you for the outstanding leadership you have provided this subcommittee. You have played a critical role in bringing congressional attention to the many needs of our Nation's veterans, and particularly the need for more medical facilities. I admire you for your sense of compassion to the veterans and your willingness to fight for principles. Your commitment and dedication are greatly appreciated by our Nation's 30 million veterans.

We are particularly grateful that under your chairmanship this subcommittee has responded to many of our veterans' needs. You have been a positive influence whose strength and compassion have gained the tremendous respect of your colleagues and those of us who appear before your subcommittee. I hope that you will take with you the satisfaction of a productive and distinguished career of service to veterans. Your achievements on behalf of veterans are too numerous for me to repeat at this time. I would like to say, however, that we have appreciated your outstanding qualities as a leader and the expertise and judgment that you have provided. I did not want to have this moment pass without publicly recognizing your excellent service.

Thank you, sir. I would be pleased to answer any questions.

[The prepared statement of Mr. Alvarez appears at p. 82.]

Mr. MOTTL. Thank you very much, Mr. Alvarez. I really appreciate those kind remarks, especially coming from a wonderful gentleman like yourself. This country owes you a great debt of thanks for your service, not only to your country over in Vietnam, but also to the veterans. It is really a pleasure to have you here this morning.

Mr. Alvarez, we are all anxious to help veterans and also help the taxpayers, if we can, to build and construct hospitals at the most efficient cost possible. You are familiar, and I think your colleagues are familiar, also, with the GAO report of December of 1981. They had two main suggestions as to how we really could save substantial sums of money for the taxpayer. One, cutting out the delay in the construction by reducing some 15 months. If you or your colleagues would address yourself to that, as to how we can implement that, and second, something I feel very strongly about, change orders, as to either how this can be administratively cured or is there necessarily legislation to come to pass that we can substantially reduce the number of change orders so that we won't have contractors ripping off the American taxpayer.

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[1] See "Revalidation of fiscal year 1984 Major Construction Projects," p. 112.

Mr. ALVAREZ. Mr. Chairman, I think we have made headway in those areas. I would like to defer the first question to Bill Sullivan, our Associate Deputy Administrator for Logistics, and refer the second part of your inquiry to Mr. Bill Salmond, our Assistant Deputy Adminstrator for Construction.

Mr. SULLIVAN. Mr. Chairman, we are very interested in pursuing the extension of the advanced planning fund to working drawings, and to that end we have begun discussions with the Office of Management and Budget. We are fully examining the issues and are not certain when we would present to this committee our recommendation in that matter. However, as noted, we have begun discussions with OMB and we would look perhaps to 1983 to coming to the committee with recommendations on this issue.

On the second point, on change orders, I believe Mr. Salmond would like to respond.

Mr. SALMOND. We certainly have to agree with you, that change orders are an area where we have to be ever sharp, always, in all of our dealings with the construction contractors and, obviously, in the design phase.

Now, we have the APF process which I believe has taken care of the problems so that we aren't going to be making program changes during design. I know that, in one of the projects that the GAO studied, a very large program change was made during construction. This was the Los Angeles hospital, when the decision was made and everyone on this committee as well as the appropriation committees were well aware of the change, of closing Brentwood Hospital and moving it to the new facility. That was a million-and-a-half-dollar change and it certainly does skew the percentages as they were reported back then.

We have made a study within the last 6 months of some 55 projects, completed projects, and our change order experience is 3½ percent, which is a vast improvement. I think one of the big things is we now are involved in having to audit any change order that is over $100,000, so that the committee need not be concerned about being ripped off in that neighborhood of price change.

Over a year ago the Inspector General's Office conducted a review of some half-dozen of our ongoing construction projects. There were no change orders there that they felt were out of order in any way.

In summation, I would just say that I think we have met the task here. As a matter of fact, in discussions with OMB, when we set aside contingency money, it is with their agreement that we are permitted to set aside for contingencies 5 percent for new construction and 7½ percent for modernization type work. It is standard in the industry.

Mr. MOTTL. Mr. Salmond and Mr. Sullivan, we want to commend you for the recent changes that you have made to save the taxpayers some money. But we would like for you to submit in writing what changes have taken place in the last year or so, what proposed changes you are going to take in the near future, and work very closely with Mr. Edgar in the 98th Congress so we can really get a handle on this. We don't want this to be an embarrassment to the VA or to the Congress. I think if we all work together under the leadership of Mr. Edgar in this subcommittee next year, we are really going to get a handle on the entire cost overruns or change orders or speed up and make more expeditious the construction of our hospitals and nursing homes.

[The following was subsequently submitted for the record:]

While we were reassured by the study referred to above which showed we do not have a serious overall contingency (change order) experience, we still believe we can improve our performance. The study revealed potential problem areas on certain types of projects which we are investigating. Further fine tuning of the APF process is also being considered to reduce programmatic changes. One recent improvement of this kind has been a greater concentration during the preliminary planning stage on the approach to be taken in actual construction to avoid conflict and interference with facility operations. We have found that better coordination at this earlier stage can avoid later design and construction changes.

Mr. **Salmond**. I might add, Mr. Chairman, that since we have had the APF fund in operation, there have been no cost overruns.

Mr. **Mottl**. That's fine, excellent.

The Chair will recognize the gentleman from Pennsylvania for any questions of Mr. Alvarez and his colleagues.

Mr. **Edgar**. Thank you, Mr. Chairman.

Mr. Chairman, I probably have two or three rounds of questions, so I will try to ask a couple now and then come back after the gentleman from Florida asks his questions.

Mr. **Mottl**. Sure. Go ahead.

Mr. **Edgar**. Thank you for appearing today. I appreciate the fact that you have brought all of your staff with you to analyze some of the questions.

The first question I have deals with fiscal 1983 medical care, medical and prosthetic research, and medical administration, and miscellaneous operating expenses appropriations accounts which you have. I have documents furnished to me that were obtained recently and these documents indicate that in these three appropriation accounts your agency will be required to absorb a total of $126.4 million in medical care budgets attributed to the 4-percent cost-of-living adjustment for Federal employees on October 1, the medicare deductions that go into effect on January 1, 1983, and the increased cost of the Federal employee health benefits that go into effect at the same time. The medical and prosthetic research program would have to absorb $3.2 million for the same purpose, and the medical administration and miscellaneous operating expenses account, roughly $850,000.

Can you give us the accurate figures that you will be required to absorb in these three programs?

Mr. **Alvarez**. Well, sir, those current figures which are involved with the absorption and raises in those areas are currently under negotiation at the OMB level, with the fiscal year 1983 supplemental process. We have reached the point where we are satisfied and our appeal on this has provided some relief. However, it hasn't reached a final determination at this point. The numbers we are going to wind up with have not, in essence, been finalized. But we are proceeding fairly well on track. We feel very comfortable at where we are now.

Perhaps General Counsel could elaborate a little bit on that.

Mr. **Murphy**. The specific numbers, Mr. Edgar, that Mr. Alvarez is referring to are embargoed at the present time pursuant to the budget review process, so I don't think at this point we can give you specific numbers.

Mr. EDGAR. How can you assure this committee at this time that the quality of health care is not going to be diminished in these three areas if, in fact, each of these three areas have to bear the brunt of the 4-percent cost of living and the other increases that are going to occur?

Mr. ALVAREZ. Sir, I think that at the position we are right now, at the level we're talking now in our negotiations with OMB, we will be assured of maintaining the quality of care needed in those specific accounts. We have been assured of at least those factors by OMB. We have the confidence at this point, but again, I cannot state any specific figures at this point during our negotiations.

Mr. EDGAR. Hospital directors that I talked to indicate that they are at a loss to know exactly how they are going to continue the quality of care in the facilities if they have to shrink again those areas.

Mr. ALVAREZ. We do not anticipate any significant shrinkage at this level. We feel confident at this point in our appeal process that we will be able to meet the needs there.

Mr. EDGAR. So you are saying you don't think the embargoed numbers or negotiated numbers will be significant enough to change or alter significantly the ability to provide medical and prosthetic research and medical administration and some of the miscellaneous operating expenses that are provided in these appropriation accounts?

Mr. ALVAREZ. Yes, sir. I feel very confident that we will not have to absorb any shrinkage or see any shrinkage on the surface that is required.

Mr. EDGAR. Thank you.

Mr. MOTTL. Thank you, Mr. Edgar.

Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman.

We have had some previous testimony on the need for cooperation between the committee and the Veterans' Administration. I would say at the outset that I am quite disturbed at the delayed report that this committee was due to receive on December 1—and I will get into detail on the Florida study—but also the study on Puerto Rico and the Virgin Islands. Has that been completed and turned over to the Congress?

Mr. MURPHY. I believe the Florida report was transmitted to Congress on Friday, Mr. Mica. The Puerto Rico report, the bed study, has not yet been transmitted.

Mr. MICA. Let me just say, if I may, for the record, Mr. Chairman, I have a set of letters that I have submitted to the VA through the committee for the last year checking on these studies, and the most current one that I have is from Dr. Custis on November 5, saying "We anticipate no problems in completing this report. It is on time and we have met every target date." As of November 5, of course, the date came and went and we received a letter saying there would be at least a 45-day delay on this report. Now, as you know, we have been very, very persistent in trying to get that report before this hearing.

For the record, I would like to have that submitted.[1]

Mr. MOTTL. Certainly. Without objection, it will be submitted into the record at this time.

Mr. MICA. And while I'm doing this, if I may submit the Florida study—and I must say, the revised Florida study, dated December 2, received here yesterday, the revised Florida study for the record, I hope that its contents will be considered in the future planning by the VA.

Mr. MOTTL. Do you want that submitted into the record also?

Mr. MICA. Yes.

Mr. MOTTL. Without objection.[2]

Mr. MICA. Now, let me get to the Florida study for just a moment. We had another hearing in this committee, and this is a copy of the hearing testimony. A number of the figures that were given to Members of Congress from the entire Florida delegation somehow have been altered in the new Florida study. One example, you talk about 1.7 million veterans in Florida by the year 1990, and over 2 million in all the information that was given to the Florida delegation. I might say that it appeares you're skimming at least half of the Florida delegation-quoted figures that the new study does not record.

Can you give me some rationale as to why the figures appear to be much lower?

Mr. ALVAREZ. I think we can satisfactorily answer those questions. Bill, would you go first on that?

Dr. JACOBY. In evaluating the number of veterans in Florida, extensive consideration was given to current census figures.

Mr. Chairman, if I may, I would like Mr. Frank Marrone of our staff to further address that particular question.

Mr. MARRONE. The data that you have concerning the veteran population from the previous hearing was based on a series of estimates that were derived from the 1970 census with adjustments made based on samples of veteran migration during the seventies, but principally based on veteran migration patterns that took place between 1965 and 1970. The result was that the models that we used to project future population numbers produced considerably higher estimates than the case turned out to be.

Recognizing the fact that we were having difficulty with the precise numbers and location of veterans in Florida, as well as in the country as a whole, we entered into a contractual arrangement with the Applied Population Laboratory at the University of Wisconsin. Based on an initial release of a 1.3 percent sample of veterans, we tried to re-estimate what the actual numbers of veterans were and where they were located throughout the country. That yielded for us an estimate in Florida of 1.5 million veterans in 1980.

The actual census data that have been released since the Florida study was prepared, the study you have, indicates now that the 1980 census of veterans in the State of Florida is 1.35 million, a considerable difference from the 1.6 and 1.7 million that was in the document that you're referring to.

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[1] See p. 285.

[2] See p. 291.

Mr. MICA. Thank you for the explanation.

Mr. Chairman, I understand that we may have the 5-minute rule on the next go around, so with one comment I will stop.

Let me say that census was done in the summer months, as you know. We talked earlier about the need to crank in local demographic factors. If ever there is a problem in the State of Florida—and I don't just mean in veterans, I mean the postal facilities, the Government facilities, social security facilities—if anybody does any count in Florida in the summer months, it is way off from what actual average annual statistics are.

Let me tell you, in this study we talked about in the next 10 years. In the area I live, in Palm Beach County, with the standard metropolitan area only gaining 6,000 veterans, this is absolutely absurd. We think we will probably reach that figure in the next year or two. I will come back to that.

Thank you, Mr. Chairman.

Mr. MOTTL. Thank you very much, Mr. Mica.

Mr. Alvarez, your statement indicates that the fiscal year 1984 construction budget represents the largest ever proposed. This doesn't mean very much without being able to compare it to something.

Can you tell us how much will be requested in your fiscal 1984 budget request?

Mr. ALVAREZ. Mr. Chairman, I am not permitted to discuss the figures we have proposed in the 1984 budget.

Mr. MOTTL. Will the dollar increase—even though you can't tell it, you have some idea, I'm sure, of what it is—take care of cost increases due to annual inflation costs in the construction industry, or will it be a real increase and attempting to catch up on a large number of deferred projects?

Mr. ALVAREZ. I can say that what we hope to see or what we propose is a large increase, hoping to catch up with a lot of the needs.

Mr. MOTTL. On page 3 of your statement you made reference to the necessity of increased construction resources if you are to continue to meet your statutory responsibilities to provide quality health care to veterans.

What is your problem in obtaining these increased resources? Is the problem OMB or——

Mr. ALVAREZ. I think that one of the things that the construction review that the agency did last year, was validated in essence, the need for our facilities out there, especially in light of the growing population of aging veterans. I think that what we are basically looking at as a massive problem is how to satisfactorily meet these needs given the limited resources and the ever-increasing limitation of resources in general. It's a problem we have to face. We, in essence, are attacking the problem, trying to resolve the problem in a logical and reasonable way by focusing on those areas of greatest need and trying to meet the most important needs in medical and nursing care while also having to cover ourselves across the spectrum.

I think it's a problem that we face in general, not just the VA, but I think the country faces this problem.

Mr. MOTTL. Thank you, Mr. Alvarez.

The Chair would recognize our distinguished colleague and chief counsel of the full committee, Mack Fleming, for some questions to be proffered on behalf of the full committee Chairman, Sonny Montgomery.

Mr. FLEMING. I would like to ask two questions, Mr. Chairman.

What is the status, Mr. Sullivan, of the prospectus for the establishment of the new Los Angeles outpatient clinic? You will recall the Appropriations Committee included funds in the fiscal year 1983 appropriation bill for this purpose. Senator Simpson, as I recall, raised some questions about the expenditure of those funds when the conference report was adopted on the appropriation bill. He indicated that this money should not be spent until a prospectus has been submitted to the Congress and the committee of jurisdiction has had a chance to review it.

Mr. ALVAREZ. Mr. Salmond can best answer your question.

Mr. SALMOND. We are right now working with GSA to define what the actual site would be at Los Angeles. We also are going through an A–104 study to see whether or not the build option is the most cost effective alternate versus lease or purchase.

Mr. FLEMING. In other words, what you are saying is the VA and GSA are now making a decision on whether or not the new outpatient clinic should be established?

Mr. SALMOND. No. There is an outpatient clinic to be established in Los Angeles. We know we have to vacate where we are.

Mr. FLEMING. Yes, and when do you have to get out? I guess that's the question.

Mr. SALMOND. Based on the House Committee on Public Works and Transportation's approval last July of a new prospectus authorizing at the existing location, a 3-year lease with a 2-year renewal; we hope it will be 5 years. However, to date GSA has only been able to negotiate a 2-year extension with the owner from August 1, 1982, to July 31, 1984.

Mr. FLEMING. Have you signed a 5-year lease?

Mr. SALMOND. No. GSA negotiates this type of lease.

Mr. FLEMING. I thought what prompted this was the fact that the owner wanted you out of the existing building——

Mr. SALMOND. Yes.

Mr. FLEMING [continuing]. And that, the owner was, according to the Public Works Committee, negotiating with the GSA about the possibility of extending the existing lease for 3 additional years.

Mr. SALMOND. Our current lease expires in July 1984 and GSA will have to renegotiate an extension at that time.

Mr. FLEMING. What you're saying is you have no problem with the lease that exists now——

Mr. SALMOND. That's correct, except we recognize a need to extend it.

Mr. FLEMING [continuing]. Until you make up your mind as to whether or not you are, in fact, going to establish a new outpatient clinic or lease additional space from GSA?

Mr. SALMOND. It won't be leased with GSA. We would probably get permission from GSA to lease it on our own.

Mr. FLEMING. I guess the concern——

Mr. EDGAR [presiding]. Would the gentleman yield just a second? How long do you think that decision will take?

Mr. SALMOND. We should have this cleaned up in about 6 months.

Mr. EDGAR. Why does the decision take 6 months?

Mr. SALMOND. In order to go through a complete study, to make a market survey and to find out what is out there. There's an awful lot of work to be done.

Mr. EDGAR. And from the point the decision is made, suppose you decide to move to a new location; how long will it take you to occupy new space?

Mr. SALMOND. That would depend upon what you're going to do, whether someone is going to build us a building, whether the building is there and we can buy it, whether you're going to rent it, and how much work has to be done to the building. It could be as short as a year; it could be as long as 3 or 4 years.

Mr. EDGAR. Do you consider this particular project in Los Angeles an emergency situation or just a normal situation to be processed through the normal procedures?

Mr. SALMOND. I think it is getting a little more attention than what the normal project would get.

Mr. EDGAR. I yield back.

Mr. FLEMING. Mr. Salmond, when do you anticipate a prospectus, if any, would be to the committee?

Are you going to have it up here during fiscal year 1983?

Mr. SALMOND. I don't know. I can't promise it one way or the other.

Mr. FLEMING. You see the problem we have here. The Public Works Committee has already reviewed the GSA's long-term lease proposal, which was 20 years at $150 million, and has apparently rejected the proposal. Rather, it would be more cost effective to build a new, independent outpatient clinic for about $30 million. If the Public Works Committee feels that way about it and the Appropriations Committee agrees and appropriates $3 million in fiscal year 1983 design funds, why wouldn't the VA expedite the process and get on with it.

Mr. SALMOND. What we are going to be coming up with is asking for construction dollars, and we don't come up and ask for construction dollars until the project has been through an APF process.

Mr. FLEMING. We aren't talking about construction dollars. You have your design funds already. Construction funds can be appropriated next year.

Mr. SALMOND. I understand that.

Mr. FLEMING. Then what is the problem of moving on with the A&E contract?

Mr. SALMOND. We couldn't complete the preliminaries in time.

Mr. FLEMING. But what you're telling me is that you haven't even located a site. The committee understands GSA owns property within 1 mile of the existing outpatient clinic.

Mr. SALMOND. We are working with GSA. We assume that if the VA is going to build a building, that's where it would be built. But there are other considerations, as to whether or not you should buy a building, whether you should rent or whether someone else——

Mr. **Fleming**. I think the Appropriations Committee has suggested new construction. I don't think there is any question about what the Appropriations Committee meant and what it has said.

The reason I wanted to pursue it is that Mr. Montgomery feels it would be more cost-effective to go ahead and build an outpatient clinic rather than talk about a 20-year lease that would cost some $150 million. Since the other body has expressed concern about not wanting to proceed until a prospectus is submitted, I was just trying to ask how long that will take, and again, I guess you're telling me it might not be submitted to the committee in fiscal year 1983.

Mr. **Salmond**. We hope to be able to forward an interim prospectus to you shortly.

Mr. **Fleming**. Thank you.

Mr. **Edgar**. I would like to yield to Ralph Casteel for a question.

Mr. **Casteel**. Thank you, Mr. Chairman.

You said something that bothered me a little, a determination being made whether the GSA was going to build a building——

Mr. **Salmond**. No.

Mr. **Casteel**. Did I hear you correctly?

Mr. **Salmond**. No. It was whether the VA will build a building.

Mr. **Casteel**. OK. Thank you very much.

Mr. **Edgar**. Does the gentleman from Florida have additional questions he would like to ask?

Mr. **Mica**. Yes, Mr. Chairman, just a couple.

I didn't understand the answer, Mr. Alvarez, on the increase—you opened with a statement that this is the largest budget ever for the VA. Is this in constant dollars, real dollars?

Mr. **Alvarez**. This is in current dollars.

Mr. **Mica**. Current dollars. So then it well could be a smaller budget in real dollars?

Mr. **Alvarez**. We can get you that information right off.

Mr. **Mica**. I would like to have that information based on constant dollars. I don't care if you use that 1960 scale that they use, 1960 to 1974, but I would like to see the comparison.

[The following was subsequently submitted for the record:]

Both in constant and current fiscal year 1982 dollars, the proposed fiscal year 1984 construction budget is the largest ever requested.

Mr. **Salmond**. Mr. Mica, that would depend upon what the actual numbers are.

Mr. **Mica**. Yes.

Mr. **Salmond**. I think Mr. Alvarez has said that we cannot divulge——

Mr. **Mica**. I understand that. The point is, for example, for purposes of explaining this to me and my constituents when I read the statement you made, if we had about $24.9 billion last year in our budget, and we go to $24.9 billion as the largest budget in history, actually it is quite a decrease because of inflation. So I know it sounds good and it may well be that it's a real increase, and that is what I would like to know and would like to see the comparison.

Also, you mentioned that 35 projects were given approval and 21 were turned down on the review procedure and you were going to submit that to us. Could we have a copy of that now?

Mr. **Sullivan**. We can give you a copy.

I might just caution that this is a draft we are giving you. But with that caveat—we will be pleased to submit that information for the record.

Mr. **Mica**. If there are any changes in the draft, if you would notify the committee, I would appreciate it.

Mr. **Edgar**. If the gentleman would yield, are you going to continue questioning on that document?

Mr. **Mica**. I would like to look at it.

Mr. **Edgar**. Let me just ask another question dealing with that document, if I may.

In the course of putting that document together, listing all of the projects in terms of rehabilitation, reconstruction and new construction needs that you have, how long did you look? Was it 5, 10, 15, 20 years down the line, or was it just the immediate needs?

Mr. **Alvarez**. This was an exercise, a review that began early this year and was completed within a few months. I will let Bill Sullivan amplify on that because he was involved with that directly.

Mr. **Sullivan**. These were just projects which could potentially be ready for consideration for fiscal year 1984. These were only those projects which could potentially have their preliminary design plans completed by this fall which would make them eligible candidates for fiscal year 1984 consideration. It was only that spectrum of projects that are reflected in the report that Mr. Mica has.

Mr. **Edgar**. In the course of trying to put those projects together, looking at those that do not have their design standards there, is there any one of your staff people that is looking down the road in terms of what your construction needs are going to be 5, 10, 15, or 20 years into the future?

Dr. **Jacoby**. Mr. Congressman, as we develop our requirements for the 5-year plan, we are looking at long range future needs in the major construction program, whether it be replacement, modernization, nursing home care, domiciliaries, and all other projects that I think you are familiar with.

The projects that you're questioning right now are those that were developed in our normal process. As we develop the budget a series of projects that are within our 5-year facility planning document will be under consideration. The projects that are ready for working drawings will be considered in the budget process. I think specifically, in answer to your question, yes, we are looking through at least the 1990's to the year 2000, 2010.

Mr. **Edgar**. One of the exercises that I would like to do in the early days of the new Congress is to try to get a large map of the United States and place on that map all of the veterans' facilities that deal with hospitals and health care, and to color code the map in some way so that we would have some indication as to which facilities are 30 years old, 40 years old, that type of thing, but also to do some analysis by looking at the map as to the regional distribution of those hospitals, the need—5 years, 10 years, 20 years down the line for replacement of facilities—and the need for major modernization for those facilities, so that we would have some way of looking over a period of time at what our needs are going to be, charting a little bit about what the dollar commitments are going to be for those facilities as well.

Dr. JACOBY. Mr. Chairman, some of the things that you have mentioned we already do. I don't want to put under emphasis on the MEDIPP process, but as we go through this process we will be accomplishing this review of demographics, locations of current facilities, and recommendations for future construction.

Mr. EDGAR. Early in the next Congress I would like to come over and have a briefing on that kind of thing and have some ability to look at those things in terms of rehabilitation reconstruction needs and location of where those facilities are at present, because I do think that at least over the next 4 to 6 years we're going to have to do some long-range planning because at the very time we have the need for new construction of facilities in Florida and other places, we have major rehabilitation needs in other parts of the country that may go unmet if there isn't some fairly careful planning.

I yield to the gentleman from Florida.

Mr. MICA. Thank you, Mr. Chairman.

What I would like to do is turn this over to the committee to be included in the record. I just had a brief moment to look at this and——

Mr. EDGAR. Without objection, the draft list will be provided for the record.[1]

Mr. MICA. I am pleased to see that two of the Florida projects will move forward, but I am discouraged to see that some of the projects around the country, as my colleague was talking about, may have to go by the boards.

I just noticed in looking—and I haven't had a chance to study this—that some of the reasons given are just due to budget considerations. I would hope we will have a chance to look at this list and make some judgments as a committee on budget considerations versus the need throughout the nation and maybe address the priorities from the committee's standpoint and have a little discussion with VA on this.

Without objection, I would like to have that included in the record.[1]

Mr. MICA. Now, I didn't understand also when we will receive the other two studies that were due on December 1, the Virgin Islands study and the—when will we receive those?

Mr. MURPHY. I can't give you a specific date, Mr. Congressman, but I can assure you that a lot of effort is being made to get them up here.

Mr. MICA. Let me tell you, the Puerto Rico study, I don't think the committee will be able to move to take any actions

Let me just add, I think you will understand my concern on all three of these studies, and maybe you can tell me this. A delay of 45 days at this time of the year does have, or could have some effect on the budget process, and with that in mind, with the fact that the Florida study was late, are you able now to crank any of the recommendations of the Florida study into the upcoming fiscal year? When will you start implementing this?

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[1] See 30-year study on the needs of veterans in Florida on page 291.

Mr. **Alvarez**. The Florida study and the other studies are ongoing efforts. They have been underway for quite a while. They sort of parallel the construction considerations and the planning we were doing. I don't see the problem as far as to what the study recommends. I think it may, in essence, parallel what we are doing in our construction planning to some degree. I know that the study, for example, the Florida study, addresses the long-range needs. There will have to be a determination on the agency's part to recommend how these needs are best met. So I don't see the conflict between the two at this point.

Mr. **Mica**. Would you advise me if I'm asking for something improper here now, but you said the Florida study parallels your own planning efforts. Could you supply us with the documents which this parallels with what you're planning to do, or would that be an inappropriate——

Mr. **Murphy**. I think that would be going too far, Mr. Mica, at this point in time, with the budget process.

Mr. **Mica**. Could you provide me with a summary of your planning efforts that parallels the Florida study?

Mr. **Alvarez**. Are you talking about the construction plan?

Mr. **Mica**. I'm not sure. Is it the construction plan or——

Mr. **Alvarez**. The construction plan, in general, I think addresses the needs throughout the country, including Florida.

Mr. **Mica**. Well, I have the construction plan with recommendations for the future fiscal years. It does not include, for instance, any of the recommendations—excuse me, I believe there is one recommendation in the Florida study. We also have the testimony that was given at the hearing by veterans organizations and members of the Florida delegation, and I think all the statistics were supplied by the Veterans' Administration. So we have one document that doesn't have Florida information in it, and we have one document with a great deal of information about Florida needs, and now we have a Florida study, and you say that this parallels some in-house planning that you're already doing.

I would like to be made aware of it.

Mr. **Murphy**. I think, Mr. Mica, what is being confused here, is that obviously when we do a study, in this case on a State like Florida or any other part of the country, the information that overlaps or may be identical is also involved in the internal budgetary process, the budgetary planning process. I don't think you would want to advocate separating the information entirely from the budgetary process.

Mr. **Mica**. No. And that leads me to another question. Of the 21 projects that were deleted, were they deleted at the express recommendation of the VA or the OMB?

Mr. **Murphy**. They were not deleted.

Mr. **Sullivan**. These projects were just not found ready for fiscal year 1984 budget consideration.

Mr. **Mica**. Did the VA identify them and defer them?

Mr. **Sullivan**. Yes. This was a review done by VA employees.

Mr. **Mica**. It was done before it went to OMB?

Mr. **Murphy**. That list is not necessarily consistent or the same as what went to OMB in the budget process.

Mr. **Alvarez**. I would like to maybe clarify that.

The review that was done was done on projects to see if they were ready for consideration. We determined that a certain number were ready for consideration and certain were not. Those that were not, necessarily would have to be delayed for further consideration down the road. That is not to say what was actually sent to OMB as a package which we are considering for VA in fiscal year 1984.

Mr. MICA. So you sent the whole package to OMB, and if they decided to approve a few——

Mr. ALVAREZ. No, sir. These 35 projects were just the projects that were determined by our review to be ready for fiscal year 1984 budget consideration by the VA.

Mr. MICA. Let me back up.

Did you send 35 projects to OMB?

Mr. ALVAREZ. What was sent to OMB was part of the 1984 budget package, which we cannot address at this point.

Dr. JACOBY. Mr. Mica, if you look at the 5-year construction plan, every year there are a certain number of projects that are considered during early stages of the process that fall out for a variety of programmatic reasons. Depending upon what we find in the APF, what Mr. Salmond finds as he does his planning and so forth, certain projects obviously are going to then be ready for budgetary considerations. The list always contains more projects in it than the number that we have in the 5-year plan, or that we submit in the budget. Therefore, based on these considerations or for budgetary reasons, some of these projects are then deferred into subsequent years.

The projects are not deleted or eliminated. Obviously, if you look at 1983, you see that some projects did move. At that stage in the normal budget process we were considering all 57 projects. Then for programmatic as well as for these reasons that are in here, not budgetary reasons, a project may be deferred. This is a normal process that we accomplish within the agency, DM&S, working with the Office of Construction.

Mr. MICA. I might say that I do understand that. I think we use the term defer instead of delete. I have worked for many years before I came to Congress as a veterans liaison, as a Member of Congress, and I have seen projects take, as we have heard testimony, 4, 6, 8, 10 years to build be deferred before 4, 6, 8, or 10 years, so the total is maybe a 20-year deferral. It wasn't deleted but it was deferred for a long period of time.

In our timeframe, I think that's as good as a deletion right now. We are concerned about the future of all of these projects, and we are also concerned about the constant comment that maybe OMB is striking items from VA's budget when it actually should be your jurisdiction trying to protect your jurisdiction.

This Florida study, I had indications, as I am sure you are aware, that one of the reasons for the delay was not you at all; in fact, I have letters from Dr. Custis and a number of VA officials that it was on target until it went to OMB. So that is my concern and that is what I was trying to highlight.

Let me move to another area for just a moment. When I asked about the study for veterans and veterans populations, someone mentioned that you did a study out of the University of Michigan, or the University of Wisconsin. Let me just point out that the University of Florida—in Florida, we talk about demographics and local information. The University of Florida in—the State of Florida has for years been recognized nationally for its expertise in demographics and studies, particularly studies about Florida population. They issue them constantly. So it may be that some of the information they already have that is free and available would be helpful to all of us.

I think their projections on Florida growth are much greater than what I have seen, and these statistics on page 4 of the Florida study, I believe a personal review by other studies, that compared to other studies, and even updated census statistics, would show these are very, very ultraconservative figures.

Now, back to the Florida study. When can we start implementing some of the recommendations? I can pick out four that could be done almost immediately. Do you have any comments?

Mr. ALVAREZ. Well, that Florida study that went forward to you, to the committee, does not reflect the views of the Administrator at this time. He has not expressed his views in regard to that particular study.

Mr. MICA. Is there any question among the top staff at VA that there is a critical situation in Florida?

Mr. ALVAREZ. There is no question as to the requirements and the needs, not only in Florida but throughout the rest of the country.

Mr. MICA. This study, for instance, talks about an addition of 1,000 hospital beds. Now, even after there was some question as to need, even after there was some question as to how conservative these statistics are, at least a 500-bed hospital would probably be most urgently needed.

I don't know if you were here, Mr. Alvarez, when we talked about the situation in Miami, the outpatient clinic down there, when several of your staff went down there, a number of committee members have been down there, and they have an outpatient facility down there designed to handle 135 patients a day. For the last year they have seen over 1,000 a day.

When they built the VA clinic in Broward County just north of Miami, there were more people receiving care—and this is why I question some of these studies—more people, more veterans receiving care from Fort Lauderdale, who lived in Fort Lauderdale, in Miami, than the VA said lived in all of Broward County. So we have reason to believe, when you are in a State that has a dramatic, phenomenal growth, that these statistics are conservative, that oftentimes there is a great disparity.

I don't want to harass the VA. I would just like to see some of these recommendations implemented as quickly as possible. As long as you are Acting Director, or the new Director comes onboard, I would love to have an immediate report, because it is a critical situation throughout the State, particularly in southeast Florida, but all over the State. Again, this report being late, somehow leads me to believe that there isn't the priority that we should have had on this. As you say, your planning and the studies we have had indicate the critical nature of the Florida situation for some time.

Dr. Jacoby. Mr. Mica, I would like to, at least for the record, state that I think the Department of Medicine and Surgery, along with the Department of Construction, is very aware of the situation in Florida. As matter of fact, on our list of 10, we have recognized the psychiatric requirements that you pointed out in this particular study. The requirements for nursing home care have always been there and to look at the projections for future years in the 5-year plan I think we can identify facilities that are projected for the State of Florida. So we're going to continue to work with you and others that are so interested in this particular problem. I can only assure you that it is on the front burner——

Mr. Mica. I hope that we do see some movement in the outpatient clinics and some movement in new construction, as well as assessing—and the report mentions assessing—the use of other facilities in the community and the military that can be used immedately to alleviate the burden and critical nature of our problem in Florida.

Thank you, Mr. Chairman.

Mr. Edgar. Thank you for your questions.

Let me ask a couple of questions and then I will yield to my colleague.

In your shopping list of hospitals that went to OMB, was the Minneapolis hospital in your shopping list?

Mr. Alvarez. Mr. Chairman, we cannot discuss anything specific in that list that went to OMB involving the fiscal year 1984 budget.

Mr. Edgar. Can you tell me why one of the top five hospitals that are listed in your 5-year plan would not have been submitted?

Mr. Murphy. Mr. Edgar, we didn't tell you it wasn't. We just said we couldn't confirm one way or the other.

Mr. Mica. Could we find out about when can you tell us? What is the soonest day?

Mr. Murphy. When the President transmits the budget to Congress.

Mr. Mica. And that day is?

Mr. Murphy. I really am not in a position to set that date.

Mr. Casteel. It will be late January.

Mr. Mica. January 25, 26?

Mr. Murphy. I couldn't say.

Mr. Mica. I would hope we could have a hearing shortly thereafter, Mr. Chairman.

Mr. Edgar. I guess I'm concerned about the Minneapolis hospital in terms of whether or not OMB has requested a down-sizing of the hospital from the 847-bed hospital in Minneapolis that we had anticipated and expected. We have seen—we thought that construction was going to begin in 1981, in 1982. It slipped in the 1983 budget, and some of us are concerned that it may slip in the 1984 budget. We need to know the size of the hospital, whether it is a priority—it either is or it isn't. We need to have some data as to whether or not this hospital is going to get the kind of priority treatment that you have accorded it in many of these previous studies to us.

I suppose what you're saying is we've got to wait until the President's submission before we know what you have done.

Mr. **ALVAREZ**. Yes, Mr. Chairman. I have been advised by counsel that that would be the wisest thing to do.

Mr. **EDGAR**. It is a little frustrating—and I recognize the need for secrecy and national defense, secrecy here and there, and even some of the secrecy in terms of total numbers requested in budgets. But it seems to me that what you have determined as your number one priority for the next 5 years, listed and ranked 1 through 10, would be cloaked in so much mystery.

Let me ask you another question. One would have to seriously question the process of revalidation of medical facility construction projects for any fiscal year when there must be within the agency a built-in process for justifying and submitting these projects to the administration, the President, and the Congress. It seems to me that, if the planning process for construction projects is faulty, the process needs to be corrected.

Why wasn't this done, rather than revalidation? What I'm asking is, Isn't it really built into the planning process of the agency?

Mr. **ALVAREZ**. Mr. Chairman, my understanding was that the questions that the Administrator was asking 10 or 11 months ago in making the determination to do a special review or a revalidation of the process, particularly as it pertained to those projects that could be potentially ready for fical year 1984 budget consideration, were: Is the scope of the project at this time correct? Is the need based on the latest information and is local demographic information being considered at the process? Where do we do a last check to make sure that all signs and systems say "go" prior to submission for the budget process?

I think that what has resulted as a consequence of this review that was taken this year is that it does validate the process, that there were areas of improvement recognized where we could make some improvement in the process. These improvements are being incorporated and integrated into the process.

We have, I think, a more confident feeling about the process in the sense that validation is being addressed at certain points throughout the process. In essence, it has given him the confidence that he needs in the process with these improvements, and that is why we are continuing on with the original process with these improvements integrated into it.

Mr. **EDGAR**. We were told earlier that it is not the goal of revalidation to reduce the budget. Is the revalidation process now tied to the budget?

Mr. **ALVAREZ**. No, sir. Bill, would you address that?

Mr. **SULLIVAN**. No, it is not at all. As we mentioned earlier, it was just a special review to see which projects could be considered. In fact, the so-called revalidation or project review is not going to be conducted again next year. So it was a one-time, interim effort to test the system, particularly until some of our procedural improvements could be made, such as MEDIPP and so forth.

Mr. **EDGAR**. I would like to yield to Ralph Casteel for a question.

Mr. **CASTEEL**. I have one question of you, Mr. Alvarez, pertaining to the Minneapolis hospital. It is my recollection that we received a communication from the VA, either in June or July—the exact date escapes me at the time—indicating that the Minneapolis hospital had been revalidated.

Now, was the revalidation at that time at 845 beds, including 120 nursing care beds?

Mr. ALVAREZ. Yes, it was.

Mr. SULLIVAN. You are quite correct, Ralph. We sent a letter up in June stating that we reviewed it and found that the need was for 845 total beds.

Mr. CASTEEL. Well, can you answer this question: Are we still talking about 845 beds for the replacement hospital in Minneapolis?

Mr. SULLIVAN. The need the agency perceives is for 845 beds.

Mr. CASTEEL. And you're telling me somebody outside the agency doesn't really agree with you?

Mr. SULLIVAN. I can't comment on that.

Mr. EDGAR. We'll learn that later.

I yield to the gentleman from South Dakota.

Mr. DASCHLE. Thank you, Mr. Chairman.

I would like to back up for just a moment because I perhaps have not been quite as attentive as I should have been. Did you say that now that the complete revalidation process is over that you will be submitting your report to us?

Mr. SULLIVAN. That's correct. In fact, a copy has been handed to the committee for the record.[1]

Mr. ALVAREZ. That's a draft copy, sir. It is the interim review exercise that the agency did on determining whether potential fiscal year 1984 construction projects were ready or not ready for consideration.

Mr. DASCHLE. Can you give me a couple of examples of what this revalidation process has provided you in terms of information?

Mr. ALVAREZ. One thing, in looking at the results it enabled us to better reallocate some of the resources. In terms of the specific needs for one hospital, we saw the need wasn't quite what we anticipated. There was a small reduction in the size of that facility enabling us to then pull in some other small projects

Mr. DASCHLE. You must have a pretty good idea, then, of how much money we saved in this process?

Mr. SULLIVAN. I can give you a couple of specific examples. There was a nursing home scheduled to go into East Orange, N.J., a 120-bed nursing home. After this review was done, we determined that the site was rather cramped, so we moved it to Lyons, N.J. They had a nursing home going in there, too, a 120-bed nursing home. So that would be a 240-bed nursing home. We don't believe there will be any delay in the project and we believe, by combining the two projects together, we will save several million dollars.

I might point out that it wasn't simply savings. There were some improvements and actual increases in projects. For instance, in Leavenworth, Kans., we had a fire-and-safety project to which we added patient privacy work in one of the buildings, because it was planned later on to do a patient privacy type of project. We found that if we combined the patient privacy and the fire and safety, we would save some money and also eliminate disrupting the facility twice. We would only have to do that once.

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[1] See revalidation study on p. 406.

Mr. DASCHLE. This is a one-shot deal; this isn't something that you're going to be doing——

Mr. SULLIVAN. That's correct.

Mr. ALVAREZ. The improvements that will incorporate additional validation steps into the normal process are being integrated now into the normal process, along with what we consider to be the better basic planning as a result of the MEDIPP process.

Mr. DASCHLE. What did this whole revalidation cost?

Mr. ALVAREZ. Bill can answer that one.

Mr. SULLIVAN. The highest estimate that we have is approximately $260,000.

Mr. DASCHLE. I assume that includes travel?

Mr. SULLIVAN. That includes travel as well as salaries.

Mr. DASCHLE. Did any of the revalidation incur a delay in construction, a delay in the governmental plan?

Mr. SULLIVAN. No. We don't feel that. We feel that the projects were not ready, for a variety of reasons, either because the design was not completed or because the mission of the facility was being reviewed. In some cases, the projects were over-scoped, which is the term we use, which means that a design is just not needed in that magnitude for that particular project. So we don't feel there will be any delay.

Mr. DASCHLE. You think it cost about $220,000?

Mr. SULLIVAN. No; $260,000, approximately.

Mr. DASCHLE. How much money do you think you may have saved in the process?

Mr. SULLIVAN. It is difficult to speculate about that. This became the process and, therefore, it is hard to know whether or not some of this cost avoidance would have occurred otherwise. I cited a couple of examples earlier. East Orange, alone, was several million dollars.

Mr. ALVAREZ. Maybe it would be better to consider some of these as cost avoidances rather than savings.

Mr. DASCHLE. We have a particular case in South Dakota that I think comes to mind as we look at revalidation. We are going through this revalidation process in a period after which apparently you had made a decision, in which it would change the mission, the role of Fort Meade and Hot Springs; at least that's what was reported. I question the proper role of revalidation, if that is the case.

Could you clarify that situation?

Mr. ALVAREZ. Could you address that, Bill?

Dr. JACOBY. Mission changes and the roles of hospitals, including construction requirements, are primary objectives of the MEDIPP process. Based upon the MEDIPP determinations, we would then address the requirements for construction which would support the mission of the facility. The services, for example, surgery, that would be planned for each facility could be determined in the MEDIPP process.

I don't think that that, per se, was part of the revalidation.

Mr. DASCHLE. Dr. Jacoby, what is the VA plan in this case? Have you made a decision?

Dr. **Jacoby**. Right at the present time, Mr. Daschle, the MEDIPP plans, which were submitted on the first of November, are under review. As a matter of fact, there is a very important internal review occurring this week. Those plans then will be put together and we would anticipate that decisions would be made regarding the MEDIPP plan in March and April of 1983.

Mr. **Daschle**. I expect you will present that information to the committee as soon as it is available?

Dr. **Jacoby**. We would be most happy to.

Mr. **Daschle**. I would hope so.

Let me follow up with some additional questions that were of interest to me last spring. During that time we were talking about not necessarily revalidation as much as the whole Inspector General program. You were kind enough to provide me with information that really led me to have some additonal questions. I am wondering if Mr. Sato could come up to the table because I would like to pursue him briefly with a couple of additional questions.

Mr. Sato, in your response—I have the hearing record before me—on page 53, you state that:

> Inspector General personnel are selected based primarily on their demonstrated ability to evaluate the complex Federal Government management process. The IG personnel are not technical but, instead, provide formal training to objectively evaluate the process by which technical persons manage agency programs.

Well, that concerned me a great deal, and I have been looking forward to pursuing this with you somewhat because it seems to me that they are performing a role for which they are not at all qualified, if that is the criteria upon which you have selected IG personnel.

Tell me again. My understanding of IG personnel was that their purpose is to demonstrate whether or not a given facility or the construction of a given facility has the necessary technical and fiscal definition to it to provide a good program. What you are telling me now is that they aren't really supposed to look at that. What they are supposed to do is look at the management of that program to see whether the management is being appropriately carried out. Is that correct?

Mr. **Sato**. Not exactly, Mr. Daschle.

For example, in our reviews of construction projects, we are primarily looking at the support and documentation that are provided to justify the project, whatever it may be. As has been stated here during the hearing, in some of our earlier reviews we found that there were some weaknesses in the system that we were concerned about——

Mr. **Daschle**. Let me interrupt for just a second.

I thought they were giving recommendations on whether a certain construction ought to go ahead, or whether a certain project ought to be authorized. Isn't that what they're doing?

Mr. **Sato**. Where we have found that the construction project, in its justification, didn't seem supported to us, we have raised those questions to managers——

Mr. **Daschle**. But you look at, whether they are supported or not, at whether the management process is working, not whether the technical aspects of the project are good; is that correct?

Mr. **Sato**. That's right. For example, in one of the projects we looked at, the initial justification which was submitted indicated a certain patient workload 5 years down the line. That particular patient workload actually had not materialized. But, at that time, we didn't have the review process to update the original justification. Where we find concerns like that, we think it is our responsibility to call it to the manager's attention.

Mr. **Daschle**. Can you recall a time in the past 5 years when IG personnel have been required to provide judgment or pass any kind of an analysis on the architectural or engineering or any of the technical aspects of a given program—strictly the technical, not the management part?

Mr. **Sato**. No, we have not.

Mr. **Daschle**. You have never done that?

Well, then, you certainly have surprised me. I thought that that was what the IG was supposed to do. I went out to Muskogee, and as I talk to people in Sioux Falls, the impression I had was the IG was looking at the architectural, the engineering, and the technical aspects of that project, to determine whether it had merit, and now you're telling me that that isn't right. I am certainly glad you clarified the record.

Mr. **Sato**. As I mentioned earlier, Mr. Daschle, we are looking at the documentary support, that is, what is the justification for the project? In every instance where we have questioned the project and it, in fact, has been deferred to be relooked at, we have tried to point out to our managers in VA where the areas of concern were. We are not questioning the engineering judgment or the architect-engineer's judgment on how a facility should be built or——

Mr. **Daschle**. But doesn't that have to be taken into consideration?

Mr. **Sato**. Yes, sir; it is.

Mr. **Daschle**. It does have to be taken into consideration, and yet the impression I have is that these people have no technical training whatsoever to take that into account and apply a judgment on those aspects.

Mr. **Sato**. It is a consideration, but our job is primarily to review the management—the resource management—process.

Mr. **Daschle**. But how do you do that if you don't have any understanding of the technical nature of the project which you are evaluating?

Mr. **Sato**. Let me give you an example. If a particular project says we need an ambulatory care addition, and we estimate *x* thousands of outpatient visits by 19—, whatever year, but those projections, for whatever reason, do not materialize, or the conditions upon which those projections were initially made do not come about, or in other cases, if there is not sufficient consideration of alternatives, we feel it is our responsibility to bring that to the attention of the managers.

Mr. **Daschle**. Do you require any specific educational planning background or analysis background before you hire these people?

Mr. **Sato**. Well, the composition of my staff currently is made up of several disciplines. In fact, we do have on our staff a number of persons who have worked in DM&S, DVB and other parts of the Veterans' Administration.

Mr. **Daschle**. But they have no formal training in regard to the audits, the technical expertise that they are supposed to have in order to provide this expertise in analysis; is that correct?

Mr. **Sato**. If we were to require specific engineering expertise, we have several alternatives. We can hire those personnel as consultants to our staff; we can give certain kinds of training on various types of projects as the case might be. As an example, I think earlier when you and I had some discussion, you raised some concerns about some of the qualifications of my staff. I looked back on some of the teams that you were concerned about. I did note that several of the individuals had a number of years of experience, not only with the Veterans' Administration, but in the audit business itself.

Mr. **Daschle**. The impression I have—and correct me if I'm wrong—is they are not technical people, that in spite of that fact they are required to pass judgment on very technical aspects, of the advisability of a given project. Certainly they have to take into account the so-called management process which, in my opinion, is a very nebulous term. If time permitted, I would be interested in pursuing that with you.

But the impression I have is that they are supposed to judge a management practice and from that I suppose, evaluate the personnel involved, evaluate whether or not the project has merit from an architectural, engineering, or medical point of view, and then present that analysis to the Administrator.

Now, they may have expertise in evaluating personnel. My concern is that they have absolutely no expertise in providing the other part of this whole process, and that is the analysis of the technical aspects of this work. That is where I think we have got to make some change, and that is why I have a concern still today, especially after having read what you submitted in writing for the hearing record last April.

Do you see any need to change this whole process? Aren't you concerned about the fact that we have less-than-qualified personnel in the IG making very technical decisions about whether or not a project needs to be evaluated, based on the fact that they have no expertise in that regard?

Mr. **Alvarez**. I think it was the Administrator's viewpoint, and still is today, that the function of the IG was merely to raise questions in areas that we feel warrant——

Mr. **Daschle**. But wouldn't you feel a little more confident if they raise questions, the fact that they had some expertise in the area?

Mr. **Alvarez**. When he raises the questions, the questions he does raise in certain areas, as far as my experience has been, have always been directed toward areas of management, areas that the Administrator or the managers should look at, not the technical areas. We are not—I agree, we have no business in those technical areas.

But when you have some results, as Mr. Sato pointed out, that vary widely from projections made a couple of years earlier, then maybe it's a question of looking at your procedure, looking at your methodology. Perhaps there are areas for improvement that would improve the process.

I really feel that Mr. Sato, along with the rest of us, has a real commitment to making sure that the services that we deliver, the medical care that we provide for the veterans, is the best that we can possibly do.

Mr. **Daschle**. I sure don't question the commitment. I just question the ability and, judging from what I have seen in the IG area, I think there is a great deal of question on whether or not they could perform in the way in which I think we expect, due to the fact they have no expertise.

[The material referred to follows:]

I have looked into the methodology pursued by the VA Office of Inspector General in its conduct of operations. In my view, the audits conducted are in accordance with established auditing processes and have been of significant assistance in the management of VA operations and programs.

As you know, the Inspector General has authority under the Act to recruit and train personnel necessary to carry out his responsibilities, without oversight by the Administrator of Veterans Affairs. Notwithstanding that lack of oversight, I am satisfied that the present staff possess the necessary experience and skills to perform audits and investigations of VA operations. The professional staff is comprised of auditors and investigators who are trained and experienced in reviewing management and program delivery operations. In this regard they have consistently conducted reviews which have led to meaningful recommendations for operational improvements.

The staff does not, in my opinion possess the necessary technical skills to initiate and execute program delivery operations. Personnel having these necessary skills are available to the Inspector General within the overall VA personnel resources, and have been called upon to provide expert assistance when requested. In addition, the Inspector General has authority under the 1978 Act to retain consultants on a temporary basis from the private sector when necessary to supplement his permanent staff. Considering the ready availability of technical personnel from other sources, I do not see the lack of such capability within the Office of Inspector General a detriment to their operations.

Mr. **Alvarez**. I would like to add that we would be happy to look at this again, take a look at the IG's methodology and look at his reports and comments and——

Mr. **Daschle**. I have taken more than my time, and I thank the chairman for his indulgence.

Mr. **Edgar**. That's OK. I apologized at the earlier hearing of having to leave and pressured you in asking the questions. I hope you had an opportunity to explore all of the questions you had. I think you have opened an interesting concern that I think needs some further discussion. I appreciate the witnesses answering your questions.

Mr. **Daschle**. Thank you very much.

Mr. **Edgar**. I would like to yield to Rufus Wilson, staff person on the minority side, for a question.

Mr. **Wilson**. Thank you, Mr. Chairman.

Mr. Alvarez, I hate to keep bringing up the Minneapolis question. But are you at liberty to discuss whether or not the whole matter of Minneapolis is concerned with a larger question—reducing operating costs for the future and perhaps not just cutting 20 or 25 percent of the beds out in Minneapolis, but cutting 20 to 25 percent of the beds out of the list of 10?

Is this not part of a larger question that is being discussed at high levels of government?

Mr. **Alvarez**. Rufus, I am not aware of any such considerations at a higher level. The reason why I would not care to discuss what is happening to the Minneapolis project in particular is because what we are talking about is the fiscal year 1984 budget.

Mr. WILSON. I realize that that is embargoed information at the moment. But if, in fact, this is a forerunner, or this is a wave of the future, it creates a broad policy question that this committee I think would be very interested in.

Mr. ALVAREZ. I think Mr Sullivan's comment to Ralph Casteel was that that particular project was revalidated or determined to be one for consideration, last summer, and at the scope and at the level we were talking about.

Mr. EDGAR. Thank you.

Do you know whether the Administrator-designee, Mr. Walters, has engaged in any dialog with the President or the Director of the Office of Management and Budget in reference to the 1984 budget figures?

Mr. ALVAREZ. Mr. Chairman, I know that Mr. Walters met with the President last Wednesday morning, but I do not know if he discussed the fiscal year 1984 budget.

Mr. EDGAR. Who in the VA has the opportunity to appeal a decision of David Stockman or the President in relationship to the dollar commitments for construction of VA facilities?

Mr. ALVAREZ. The Administrator, sir, has the authority to appeal.

Mr. EDGAR. Have you had experience in the past of these appeals being successful?

Mr. ALVAREZ. I have found to some degree that yes, they have been successful.

Mr. EDGAR. So that even while these numbers are embargoed, there is a constant process of dialog and give and take and appeal with the OMB, so that the figures that are coming out are not solely those of OMB?

Mr. ALVAREZ. Well, Mr. Chairman, I don't know what figures that are coming out you're referring to, but we are in the process of constant dialog and are working to a satisfactory level.

Mr. EDGAR. It would be my hope that over the next couple of weeks, as this budget process moves, that there will be some active consideration because of the $1.675 trillion commitment we have made to defense expenditures. With that kind of pressure on the budget over the next 5 years, the kind of money you're talking about for veterans' facilities is a prime target. It is a discretionary budget; it is a budget that looks like it can be picked apart or delayed or recycled. I can tell you that some of us on the committee are concerned about the future of the veterans' health care system as we move on into the future, given the pressures of that defense budget. We're going to spend $38 million an hour every hour for the next 5 years, whether it's good for us or not. It's a concern that those items that are in the discretionary side are going to get a great deal of pressure.

Let me just ask you a few remaining questions.

It is my recollection that you were directed to decentralize the project management for the construction of nursing care units in Tampa, Ann Arbor, and Fresno. Can you give us a status report on these three units?

Mr. **Alvarez**. Mr. Chairman, I think one of my colleagues could better answer that particular question.

Mr. **Sullivan**. As I recall, awards have been made for preliminary design plans on all of those projects. To the best of my recollection, they are proceeding in design at this time.

Mr. **Edgar**. Would you happen to know——

Mr. **Salmond**. If I may, the Tampa project, they have taken bids on construction and they are under construction. At Ann Arbor, they are also under construction. At Fresno, they are still in the design process.

Mr. **Edgar**. What will be the per bed cost of these three units when finally completed compared to the funds requested to be appropriated for them?

Mr. **Salmond**. I don't have that information at hand, sir. We can provide it for the record.

Mr. **Edgar**. That would be very helpful.

[The material referred to follows:]

Based on construction contract awards for the Ann Arbor and Tampa Nursing Home Care projects, it appears that the ultimate per bed cost will be substantially below the budgeted per bed estimate. Construction bids for the Fresno project will be received later this year. Final costs for these projects will not be available until technical services and contingency costs can be obtained after completion of construction. The bids received for the Ann Arbor and Tampa projects are consistent with recent experience on all projects which shows that low bids are well below budget estimates.

Mr. **Edgar**. What are the current plans for providing outpatient services for veterans in the northwest Indiana area?

Mr. **Alvarez**. Dr. Bill Jacoby.

Dr. **Jacoby**. Obviously the northwest Indiana area has been very well studied, Mr. Edgar, and we incorporated that again into our MEDIPP planning processes. As I mentioned earlier, those results should be available in March or April. I hope then we will be able to address our requirements for northwest Indiana at that time.

Mr. **Edgar**. I think it is important for us just to focus on that project. Even after the death of our colleague here, there is a number of us who traveled to that part of the country and looked at that project and have some strong feelings, that the trip into Chicago is a difficult trip for many of the veterans who live in that area. It would be hopeful that we could get some data on that particular project as soon as possible.

Let me ask a final question and then there may be other questions from staff.

At the hearings before the subcommittee on April 1, 1982, I directed a question to Administrator Nimmo concerning the redesign of the budget process to include a separate capital budget. According to a recent GAO report, which I circulated at the witness table, capital budgeting could be one way to consolidate and more adequately plan for major capital improvements. Since that time Congressman Bill Clinger from Pennsylvania and I have introduced legislation dealing with the capital budgeting concept which would require a national facilities assessment be made of all of our capital infrastructure, highways, bridges, water and sewer projects, veterans hospitals and health care facilities, et cetera, to try to prioritize that list and look at some imaginative ways of funding reconstruction, rehabilitation, and new construction. We have gotten some interest from Secretary Drew Lewis, the Secretary of Transportation, and Secretary Regan in a press statement in the New York Times indicated that "we will have to look at the capital budgeting concept." We had some indication on the House floor last week when the transportation bill was up, that the chairman of the subcommittee dealing with surface transportation indicated earlier in the next Congress we would be dealing with capital budgeting. The chairman of the full Public Works and Transportation Committee is interested in the issue and will be moving a bill early in the next Congress on that issue.

At the earlier hearing Mr. Nimmo indicated—and I quote—"we certainly will be eager to engage in conversations with OMB on this matter." Do you know, or could you tell me whether discussions have taken place, initiated from the Administrator's office, on the issue of changing the budget process and looking at the capital budget concept?

Mr. ALVAREZ. Mr. Chairman, I personally do not know the answer to that. Perhaps one of our colleagues could answer that better.

Mr. SULLIVAN. There hasn't been any opportunity or invitation to discuss that with OMB.

Mr. EDGAR. It would be my hope that those of you in the VA and on the staff might take a look at the dialog and the information that is being shared about the possibility of moving toward a capital budget within the unified budget structures, perhaps to review the hearings that were held in the Economic Development Subcommittee of Public Works dealing with that issue.

As you know, every major business in the United States has an operation budget and a capital budget. Most of the States have an operation budget and a capital budget. The Federal Government, because it uses the unified budget process, doesn't separate out its short-term, medium-term or long-term capital investment needs. Therefore, we get into a problem of replacement and rehabilitation and new construction of facilities down line. In some instances I think the Federal Government assumes that the facilities we put in place are going to last forever.

It would be helpful if the VA could take a look at some of the literature that is being developed on this issue, because I can assure that the question is going to be asked, not so much that we have to move to a fancy new budget process, but we ought to be able to figure out how much of the $800 billion of the 1984 fiscal budget is committed to capital improvements and how much of it is operation expenditures.

That concludes the questions I have. I would like to yield to staff at this time if they have further questions.

Mr. FLEMING. Mr. Alvarez, may I direct a question to Mr. Murphy. I was asked, Mr. Murphy, to ask this question, and I have already talked to a member of your staff to alert you to the fact that it was going to be asked. It has to do with H.R. 6681. This is a bill that would remove certain restrictions on the use of property in a county in Mississippi.

There was a letter written, as I recall, back in mid-1981, I guess from the General Counsel to someone, suggesting that although this did not represent the official views of the administration on the bill, that at that time they would certainly pose no personal problems in moving with that.

Could you tell the chairman whether or not, in your view, that has changed? Would the administration, to your knowledge, have any objection if we were to move with that legislation in the next session?

Mr. MURPHY. I can't really say the administration's recommendation. I can say——

Mr. FLEMING. The agency.

Mr. MURPHY. I can say that, as I understand it, the problem really arises from a deed restriction prior to the time the VA had title to the property, which would then have transferred on. Given that situation, again emphasizing the word "personally," from what I know I would not personally see any reason to oppose it at this point.

Mr. FLEMING. There is an official letter from the chairman asking for the official administration views this year, and he just wanted to ask if you envisioned any problems as you see it——

Mr. MURPHY. Not at this point.

Mr. FLEMING [continuing]. Recognizing full well it is not official.

Mr. MURPHY. Not at this point.

Mr. FLEMING. The final question that I would have, Mr. Chairman, is what is the status of the Houston replacement hospital?

Mr. SULLIVAN. As you may recall, the letter came up to the committee indicating that we had put Houston on the fiscal year 1983 advanced planning fund. That just occurred.

Mr. FLEMING. Which means?

Mr. SULLIVAN. The VA will initiate conceptual development and preliminary design of the project.

Mr. SALMOND. It could be 1985, but looking at the timeframe right now, for a job that big, it probably would be 1986.

Mr. FLEMING. May I ask Dr. Jacoby a question? A question has now arisen having to do with the use of the old facility after the new hospital is completed. Mr. Montgomery visited the medical center recently and he has expressed some interest in the possibility of utilizing some of the old buildings there for a regional office. The regional office could be moved from the current leased facility to the hospital grounds. It makes sense for a variety of reasons.

Is it possible this could be done? The question I guess I'm asking is, has a decision been made whether to utilize the old building for medical purposes when the replacement hospital is completed?

Dr. JACOBY. I don't believe that final decision, Mr. Fleming, has actually been made. What we are doing now is studying the facilities to determine what would be our best plan for providing health care in the Houston area. Obviously, this review would include plans that would be directed toward total replacement; therefore, there would be part of the old facility still available.

There are other plans which are being evaluated which would retain sections of the current facility, but obviously, under either one, there could be areas within the current facility that could be utilized for the regional office. There would be space available.

I would ask Mr. Salmond if he has any further information.

Mr. **Fleming**. Well, that generally tells me what I need to know for the chairman.

The agency is well aware of his feelings concerning the excessing of VA property. He doesn't like to excess any VA property. He recently received a letter on a survey that was conducted at Knoxville, Iowa, suggesting that 43 acres, according to GSA, could be excessed, and declared surplus.

Knoxville is about 40 miles from Des Moines. The chairman feels the 43 acres there could be utilized at some future date by moving the regional office there instead of leasing space in Des Moines at a cost of about $312,000 a year.

Has the agency given any consideration to looking at VA medical centers where there is adequate land, and using the land for the construction of a regional office? This seems reasonable where the hospital and regional office is located in the same city or within—reasonable commuting distance.

Mr. **Salmond**. Yes. As a matter of fact, we are doing that in South Dakota. As you recall, we are moving back on the site.

Mr. **Fleming**. There are several places Mr. Salmond, where it might be possible to do this. Possible stations might be Columbia, S.C., you've got space at the hospital there; Des Moines and Knoxville, Iowa, a commuting distance of 45 miles; Waco, Tex.; Milwaukee, Wis.; Nashville and Murfreesboro, Tenn.; St. Petersburg and Bay Pines, Fla.; and Chicago.

Could you submit to the committee, just so the chairman would have some idea, of what facilities you have, both hospitals and regional offices, in States within a 50-mile commuting distance? [1]

Mr. **Salmond**. We can do that. It's a geographical exercise, but whether or not Miss Starbuck and the Chief Medical Director are in tune with this, and the position of the administration, I don't know. I know that they do consider this thing from time to time.

Mr. **Fleming**. With the budget defecit being what it is, one has to wonder why the agency would spend a half-a-million dollars a year for a regional office when it has 43 acres that GSA is asking to be declared excess, that is only 40 miles away. It seems someone should be looking at this.

Mr. **Salmond**. I think if I were Dorothy Starbuck, I would question whether I really wanted to move 40 miles away from Des Moines.

Mr. **Fleming**. Well, I don't guess it is Dorothy Starbuck's decision to make. It is a decision for the Administrator to make.

The Administrator has to decide whether to continue to lease space from GSA when he is being forced by the same Agency to excess VA property within the same city or within a reasonable commuting distance.

I don't see where the decision would be too difficult.

Mr. **Alvarez**. Mack, I would be pleased to work with Dorothy Starbuck and DM&S and discuss this, look at this, and get back with you and report to you on the problems and advantages we see. I think this is something we need to look at.

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[1] See p. 419.

Mr. **Fleming**. Mr. Alvarez, I don't want to create the impression that the chairman is advocating the moving of regional offices. He certainly is not.

Mr. **Alvarez**. I understand.

Mr. **Mottl** [presiding]. Thank you, Mr. Fleming.

Recently we received a letter from Bob Lynch, the director of the National Veterans Affairs and Rehabilitation Commission of the American Legion regarding the VA medical center in the Bronx, N.Y. I will make this correspondence a part of the hearing record, without objection.[1]

Mr. **Mottl**. I am going to ask our chief counsel of the subcommittee here, Mr. Casteel, if he would be kind enough to read excerpts from the documents and then we will submit to you questions to be answered in writing. It will be a part of the record at that time and we will hold the record open until we receive those answers.

Mr. Casteel.

Mr. **Casteel**. Mr. Chairman, I will be as brief as possible. The Veterans' Administration staff was furnished a copy of this document this morning. I don't know whether they had one previously or not, but at least we felt they should have it. This is a letter dated November 24, from Mr. Lynch to you. It has two enclosures which I will just read excerpts from, very quickly.

The first one is, "Today, there are approximately $1.7 million worth of safety deficiencies built into the VA hospital in the Bronx, New York. Breakdowns are: complete failures of some equipment is common; the pneumatic tube system has never been operational and may never become properly operable."

To go on to a [illegible] hers, "Absenteeism and traumatic injury abuse have been [illegible] lable; due to the lack of qualified nurses, the non-bed [illegible] sive care unit had to be closed down; there has been [illegible] four total blackouts of the hospital; this has occurred [illegible] erating room procedures and dialysis treatment.

"The construction [illegible] rsing care unit is scheduled for the near future. It is currently in the design phase. The same architectural engineer who designed the hospital is being used. While the hospital was being constructed, the CAT scanner went through two summers in an unair-conditioned room. Since being installed, it has been down more than it has been working."

Just to wind it up with a couple more, "The dialysis unit is located on the 9th floor. Attempts made to have this inane site changed while still in the design phase were unsuccessful. Getting the proper water pressure to the top floor has been a major concern. If this unit ever goes out of service for 2 or 3 days, there is no place in New York City that would be able to handle the extra workload.

"The equipment in the cardiac stepdown unit has been on station for 16 months. The electrical contractor defaulted on connecting the wiring to the rooms. The engineering service is in the process of attempting to correct this.

"The air in the operating room has been of major concern. The air intake valve for this area is located near the loading dock. The truck exhaust fumes are being drawn into the operating room.

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[1] See page 321.

When VACO was asked what could be done to eliminate this design flaw, the reply was to have the truck drivers turn off their engines.

"The surgical intensive care unit and the operating rooms are separated by two floors—" and it goes on in this vein, Mr. Chairman. But let me just wind it up with one in the Rehabilitation Medicine Service. "Some outlets had to be disconnected because they were fire hazards. In one area in the occupational therapy clinic, for some obscure reason recessed floor outlets were placed in this clinic. When building management washed the floors, it was discovered that these outlets were not waterproof. They have been disconnected and cover plates placed over them, but the concave areas are still present. This is a highly potential safety hazard."

Mr. MOTTL. Mr. Alvarez, if we could have your immediate attention to this problem, it sounds like it's horrendous and it is very difficult to believe that such things are going on. If you would like to address yourself now to it, you may.

Mr. ALVAREZ. Mr. Chairman, they do sound like they are serious. We will take immediate note of this and provide answers to the questions for the record.

Bill, would you like to comment on this?

Mr. SALMOND. Yes. Mr. Chairman, many of these items that are being aired right now in this letter, they are rather old. Many of them had been taken care of long ago. The letter surprises me. Obviously, it's in the agency and we will be responding to it, each and every item.

Mr. MOTTL. We would appreciate that, if you could give your immediate attention to it and give us a letter in response.

[The material referred to follows:]

The VA has investigated these allegations and is in the process of providing a response to the Committee. We anticipate responding to the Committee very shortly.

Mr. MOTTL. The subcommittee would like to thank you, Mr. Alvarez, Dr. Jacoby, Mr. Murphy, Mr. Sullivan, and Mr. Salmond for your testimony here this morning and your answers to some of the difficult questions. We certainly appreciate your continuing cooperation with this subcommittee.

Mr. Hammerschmidt is going to submit some questions for the record, if you would be so kind enough to answer them.

[The questions of Mr. Hammerschmidt appear at page 343.]

Mr. MOTTL. Yes, Mr. Nelson.

Mr. NELSON. Mr. Chairman, would it be possible for Mr. Alvarez and his colleagues to remain during my statement?

Mr. MOTTL. Sure. You mean you want them to listen to your statement?

Mr. NELSON. Yes.

Mr. MOTTL. Certainly.

Again we want to express our deep appreciation, and if you would be kind enough to listen to the testimony to be given by our esteemed colleague from Florida, Bill Nelson.

Bill, we would like to welcome you to the subcommittee. You are one of our most distinguished colleagues. You do a great job not only for Florida but for the whole Congress, and we want to welcome you here this morning and we look forward to your statement.

STATEMENT OF HON. BILL NELSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. NELSON. Indeed. Mr. Chairman, I apologize. I intended to be here at the time that Mr. Mica was making his presentation, but a "gremlin" attacked my throat last night and early this morning I was speaking as if speaking through wax paper, so if you will please excuse my tardiness.

What I wanted to do, Mr. Chairman, while Mr. Mica, my colleague from Florida, was sharing with you gentlemen from the VA, first to thank you, that under extremely stressful conditions the VA is providing a much needed and appreciated service in our State of Florida. I would like to point out, as you well know from the study that you all have completed and I assume have released today or this week, the 30-year needs of veterans' facilities in Florida, you are well aware that we have in excess of 6,000 veterans per month moving into our State and, as a result, in trying to be dutiful and responsive Congressmen to the needs of our constituents, we find the facilities that are there extremely overtaxed because, just to handle the sheer volume, they are not adequate.

Then, when you compound that during the winter months, when so many of our veteran citizens from our colleagues' States in the North are coming to Florida because of the climate that we are blessed with during the winter months, and expect, rightfully so, attention from the medical facilities of the Veterans' Administration located in our State, then we all the more compound the problem for our resident veteran population.

Now, I come from a part of the State where we have an extreme concentration of veterans. As a matter of fact, in your listing here, within the top seven areas of the State, two parts of my congressional district—namely, the SMSA of Orlando, as well as the SMSA of Melbourne, Cocoa, and Titusville—are ranked within the top seven areas. The closest hospital for our veterans population to go to is Tampa or Gainsville, which is a considerable distance and a fairly long ride.

We do have a veterans outpatient clinic in Orlando, and I want to share with you that when I came to the Congress 4 years ago we had so many problems of overcrowding there that I went and pleaded to the then Administrator, Max Cleland, telling him of the severe strain on that facility and asking him if he would make a personal visit there, which he did in 1979. During that tour he said this was the most crowded VA outpatient clinic that he had seen in the country. Because of his personal intervention, we were able to almost double the size of that outpatient clinic. And yet we knew at the time that it was being constructed that, the minute it opened in its doubled capacity, it was going to be behind the curve and it was not going to be adequate.

I had held out the hope to a lot of nonservice-connected disabled that they would begin to start receiving attention once we had that doubling of the capacity, and yet, in fact, once it opened they had to go back down to the bottom of the priority list and the service-connected had to be taken care of first and they are not receiving that attention.

In my home area of the Melbourne, Cocoa, and Titusville SMSA, of which we are in the range of about 55-60,000 veterans population, there is no outpatient clinic located. There is one that is planned to the north, about 110 miles, in Daytona Beach, but they have a population of veterans in the range of around 30,000. So there is just simply the need for more facilities in the area.

Now, let me conclude with this, Mr. Chairman—and you are very kind, Mr. Chairman, to allow me this opportunity.

About 2 months ago I went to visit with Mr. Nimmo. I arranged the meeting so that I could meet with him in Senator Chiles' office. We pled our case to him and Dr. Custis. Shortly thereafter the Administrator announced that he was going to be resigning. So I could not let this opportunity go without bringing our case again to the highest authorities in the VA.

Mr. Nimmo was most receptive. He spoke of this study without revealing its contents and had indicated the timetable, that when this study came out he would be making a decision in about January as to what the future 5-year construction plan was going to be.

Let me conclude my statement with a question, then, Mr. Chairman. In view of the fact that the administration within VA has changed, is there still such a timetable, and what kind of information can I share with my veteran citizens as to the future attending to their medical needs?

Mr. ALVAREZ. Thank you, Mr. Nelson.

I want to assure you that we are seriously addressing all of the needs, as you indicated, not only in the State of Florida, but throughout the country, but particularly Florida. We are paying particular attention to all of these specific requirements as they have surfaced throughout. I want to assure you that we will continue to focus our attention and our resources to this problem.

As far as the timetable which you indicate Mr. Nimmo had indicated he would be sending here in the near future, I cannot address that question, but perhaps one of my colleagues has more information on that. Let me go back and see if we can come back to you in the very near future addressing this timetable. I just don't have the information on it right now. I would like to find out what that decison or that statement was based on before I come back to you.

Mr. MOTTL. Mr. Alvarez, would you be kind enough to work with Mr. Nelson on this project, because it is very important to him and his district.

Mr. ALVAREZ. Yes, it is.

Mr. MOTTL. If you would be kind enough to give it your immediate attention, we would certainly appreciate that.

Mr. ALVAREZ. I will certainly followup on this as soon as possible, sir.

Mr. MOTTL. Bill, thank you very much for appearing before our subcommittee this morning. We really appreciate that, and we appreciate the cooperation of Mr. Alvarez and his colleagues here today.

Next, without objection, we will have the testimony of Senator Rudy Boschwitz submitted into the record, without objection.

[The statement of Senator Boschwitz appears at p. 349.]

Mr. MOTTL. Our next panel of witnesses will be Mr. Paul Egan, Deputy Director, National Legislative Commission, the American Legion; Frank DeGeorge, Associate Legislative Director, Paralyzed Veterans of America, accompanied by Earl Kelly; Donald H. Schwab, Director, National Legislative Service, Veterans of Foreign Wars; and Gabe Brinsky, National Service and Legislative Director for AMVETS. If they would all come forward for their testimony as a panel, we would appreciate their cooperation.

The Chair would like to welcome all of you gentlemen here this morning. You people have been wonderful to work with and we appreciate your cooperation. You certainly are outstanding representatives of your service organizations. Again, I want to welcome you this morning and look forward to your testimony.

Your written statements will be submitted into the record in total, without objection, and you may proceed as you deem fit.

First of all we will hear from Paul S. Egan, Deputy Director, National Legislative Commission, the American Legion.

STATEMENTS OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; ACCOMPANIED BY PAUL S. EGAN; FRANK R. DE GEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ACCOMPANIED BY EARL KELLY; DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND GABRIEL P. BRINSKY, NATIONAL SERVICE AND LEGISLATIVE DIRECTOR, AMVETS

Mr. EGAN. Mr. Chairman, John Sommer, our Deputy Director of National Veterans Affairs and Rehabilitation, will summarize our remarks. But I would like to make just a couple of remarks.

Notwithstanding the talk that we're hearing in some quarters of Congress that the 97th may run as late as New Year's Eve, we certainly don't want to miss an opportunity to thank you for your leadership as chairman of this subcommittee and as a participant in the full Committee, and certainly as a leader within the entire veterans' community at large.

Mr. MOTTL. Thank you very much, Mr. Egan. I appreciate those nice remarks.

Mr. Sommer.

STATEMENT OF JOHN SOMMER

Mr. SOMMER. Thank you, Mr. Chairman.

The American Legion appreciates this opportunity to address the VA medical construction program and especially the recent move by the Office of Management and Budget to reduce the size of the replacement hospital in Minneapolis by 200 acute care beds. To us, such a proposal is untenable and preposterous, especially since the VAMC in Minneapolis is probably the most studied, researched, debated and considered hospital in the entire VA hospital system. The process has consumed years, during which the cost of the replacement hospital has escalated steadily under the impact of inflation.

As is explained in detail in our prepared statement, OMB's proposal of 525 acute care beds would not even accommodate the current patient load, much less the increased numbers of veterans expected to seek treatment at that facility by 1990.

The average daily patient census for fiscal year 1983 to date at Minneapolis is 602 veterans in 738 acute care beds. A more recent example, on December 2 the average daily patient census was 641 patients, or a bed occupancy rate of 86 percent. The action taken by OMB is a clear example of the potentiality for danger created when a vacuum exists in the leadership of the Veterans Administration, and it is not the first time that OMB has taken advantage of the absence of an Administrator to initiate an attack on veterans' programs. It was for that exact reason that our National Commander in early October dispatched a telegram to the White House, encouraging the President to immediately nominate as Administrator a veteran with the qualifications necessary to serve as an effective spokesman for veterans while capably administering an agency the size and scope of the VA.

We offer the thought to the subcommittee that it should request of OMB Director David Stockman the reasons for calling for the 200-bed reduction in the Minneapolis facility, despite the fact that the project had undergone extensive congressional oversight, as well as his justification for doing so without consulting with the House Committee on Veterans' Affairs.

With respect to our review of the GAO report, entitled "Opportunity to Reduce the Cost of Building VA Medical Facilities", it would appear to the Legion that the VA needs to be more precise in its planning of construction projects. As to GAO's statement that an extension of the advanced planning fund to allow VA to contract for final designs while Congress reviews the projects could reduce overall project costs, we would support legislation necessary for such an extension of the fund, given evidence that such an amendment would be cost effective and that the advanced planning fund would be sufficiently funded. As we understand, funding has been a problem in the past.

Unfortunately, we are unable to address the 5-year medical facility construction plan. As has been mentioned, former Administrator Nimmo saw fit to undertake a revalidation of the projects contained therein and we are without information on the specific results of the study.

What the Legion did do in response to the revalidation project was to extract from our file of site visit reports by our field representatives information relating to construction needs at the identified projects—and exhibits have been prepared for each of them. Our information indicates clearly to us that in almost every instance the projects were reflective of the actual needs within the system and, Mr. Chairman, we would welcome the opportunity to provide you with copies of our reports for perusal and any other use deemed appropriate by the subcommittee.

Mr. MOTTL. We would like to have those reports attached to the committee hearing today for our edification.[1]

[The statement of Mr. Sommer appears at p. 353.]

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[1] See American Legion on-site visitation reports on p. 112.

Mr. MOTTL. Thank you very much. We certainly appreciate your very interesting and informative statement here this morning.

Next we will hear from Frank DeGeorge, and also Earl Kelly, on behalf of the PVA. Mr. DeGeorge.

STATEMENT OF FRANK R. DeGEORGE

Mr. DEGEORGE. Thank you, Mr. Chairman, and members of the subcommittee. Mr. Earl Kelly and I are both associate legislative directors who serve in representing the Paralyzed Veterans of America. We would like to take this opportunity to thank you for appearing here today.

We recognize your diligent efforts during the 97th Congress and in the past to have the Veterans Administration's medical and health care programs and services funded as adequately as possible during this time of fiscal restraint. Our appreciation is also extended to your excellent staff for their capabilities, cooperative efforts and support. Each of you continues to remember that the men and women who have served this great Nation in uniform are owed a debt, one that must never be forgotten. PVA thanks each of you.

I would like to summarize PVA's testimony and respectfully request that our longer prepared text be entered into the record.

Mr. MOTTL. Without objection, so ordered.[1]

Mr. DEGEORGE. PVA shares your interest and your concern for the construction of VA facilities. We, like you, are concerned that the costs are great. While we recognize that veterans' medical and health care needs require attention, illness has no regard for money. However, PVA believes that the VA health care system cost effectively serves veterans and we think that some changes could make it even more cost effective.

One way would be for the VA to complete, as early as possible, the revalidation needs assessment studies. The importance cannot be overstated to making sure that a factual demographic study not be allowed to become a stalling tactic whereby the construction of needed VA facilities is delayed or cancelled merely for policy reasons, which would not benefit those for whom the VA system exists. The longer it takes to complete the needs assessment study, the more costly it will become to meet those needs for new construction and renovation of VA facilities required to provide care for ill and aging veterans.

PVA suggests also including VA facilities as part of the Federal infrastructure, to be renovated under the provisions of a restoration employment measure. Whether the restoration employment measure is financed solely through increased Federal taxes on gasoline, through general revenues, or through a combination of sources, PVA asks that the VA's medical and health care facilities be regarded as part of the Federal infrastructure which is to receive needed construction and renovation.

VA health care facilities, like the interstate highway system, are part of the Nation's assets and both were designed to contribute to the national defense. The interstate highway system was intended to allow rapid mobilization in times of national emergencies; VA hospitals were meant to care for the men and women who have answered the Nation's call to service.

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[1] See p. 364.

An example of the decay which PVA has observed within the VA health care system is the Brockton, Mass. VA Medical Center. Briefly, the spinal cord injury center there is in urgent need of renovation, and the center is filled to capacity, while other spinal cord injured veterans await admission. Yet the VA speaks of bed reductions largely because of the facility's poor condition and the major renovations which would be required to make the spinal cord injury facility fully operative.

The VA has led the Nation in the development of spinal cord injury care, but even this noble venture is being allowed to deteriorate due to economic difficulties and fiscal policies.

The VA and the Paralyzed Veterans of America have been working closely together to study the demographics of spinal cord injury veterans in an attempt to more accurately identify the location of such veterans and to examine their usage of the VA health care system. The study is being prepared by the VA and it is nearing completion.

Although the study is not completed, based on statistics available, and even more strongly, based on our observations, most of the VA's spinal cord injury centers are filled to capacity continuously, depending largely upon their location. It is apparent that the Veterans Administration requires more spinal cord injury beds and additional spinal cord injury centers if it is to meet the needs of spinal cord injury veterans.

The demographics reflect the need for the establishment of spinal cord injury centers in Dallas, Tex. and Albuquerque, N. Mex.

There is a drastic need for additional spinal cord injury centers in the Southwest because of the great distance separating veterans from existing spinal cord injury centers and because of the large number of spinal cord injured veterans who reside in the area. Medical region 6 covers an enormous area of land ranging from western Texas to California, but it contains only two spinal cord injury centers.

PVA has investigated the sites thoroughly and we have discussed our findings with the VA. It is known, for example, that conversion of an existing building at the Albuquerque VA medical center would cost only $5 million. The building is only 5 years old and is scheduled for demolition.

It is also known that the Dallas, Tex. VAMC already reports the highest number of discharges of SCI veterans of any non-SCI facility in the VA health care system. PVA noted before this subcommittee on July 28, 1982, that spinal cord injured veterans are aging and there is an existing need for long-term care facilities. PVA feels its specialized spinal cord injury long-term care facilities must be co-located with spinal cord injury centers if the spinal cord injury veterans are to receive the most appropriate care in the most cost effective manner.

Our comments concerning spinal cord injury long-term care facilities, like those made concerning specific spinal cord injury centers at Dallas and Albuquerque, are based on our observations and on the VA's statistical findings.

The spinal cord injury center at the Tampa, Fla. VAMC, for example, now works at or within one bed of 100 percent occupancy on a daily basis, and some of those spinal cord injured veterans actually need long-term care, not more expensive spinal cord injury beds.

PVA's efforts to have established at the Tampa VAMC a long-term care facility have been frustrating, as we have witnessed needless delays, delays which we believe continue to cost taxpayers needlessly. The Tampa spinal cord injury center is overcrowded and there is a continuous waiting list for patient admissions. The Tampa spinal cord injured urgently need to have a long-term care SCI facility co-located with it, especially since only California has more spinal cord injured veterans than does the State of Florida.

The Houston, Tex., spinal cord injury center, like that at Tampa, remains overworked and at near full capacity. It requires the establishment of a long-term care spinal cord injury facility if it is to meet the needs of spinal cord injured veterans in that area. Under existing conditions, the Houston spinal cord injury facility is having to care for spinal cord injured veterans who would actually benefit from services available in long-term care facilities.

In conclusion, Mr. Chairman, and members of the subcommittee, PVA asks that the VA conclude the revalidation studies as quickly as possible, and we seek to have VA facilities made a part of the Federal infrastructure which will receive renovation under the employment measures now being considered in Congress and the administration.

Finally, demographics reveal the need for the establishment of two new spinal cord injury facilities, as noted above, and of two new long-term care facilities for spinal cord injured veterans. These demographic findings are in keeping with the VA's larger use of demographic studies for the placement of all VA health care facilities. PVA feels that there is sufficient evidence to show that these new spinal cord injured facilities are urgently needed. The diligence of the members of this subcommittee remains ever important to insure the maintenance of the veterans' programs when Congress convenes on January 3, 1983. The members of PVA and all veterans are fortunate to have such concerned and dedicated advocates in the U.S. Congress.

This concludes my statement, and I will be glad to answer any questions that I can.

[The statement of Mr. DeGeorge appears at p. 364.]

Mr. MOTTL. Thank you very much, Mr. DeGeorge, for your excellent statement. We certainly appreciate it.

Next we will hear from Mr. Donald H. Schwab, director, national legislative service, Veterans of Foreign Wars of the United States. Mr. Schwab.

STATEMENT OF DONALD H. SCHWAB

Mr. SCHWAB. Thank you, Mr. Chairman. As requested, I will summarize my testimony and attempt not to be redundant.

My name is Donald H. Schwab and it is my privilege to serve the more than 1.9 million men and women of the VFW as their national legislative director.

Mr. Chairman, we, as the other witnesses here, are quite concerned about the size of the Minneapolis hospital. Few facilities have been more studied, more justified, and we intend to continue to pursue this 845-bed hospital and its funding through OMB and the budget appropriations committees at the appropriate time.

Mr. Chairman, notwithstanding that the director of our VFW national veterans service is a member of the Administrator's Facility Planning and Construction Committee, we do not know at this time which projects have been revalidated other than the replacement hospital in Minneapolis, Minn. We have been advised that of the 57 projects to be funded in 1984, 35 have been revalidated, 21 deferred, and 1 canceled. Therefore, not knowing which projects fall into which category, it is not possible to intelligently discuss the 5-year construction plan.

Members of the FPCC were advised the revalidation would be completed by September, and following approval by the Office of Management and Budget, released to Congress and the veterans' organizations. We now understand this information has been embargoed as a budget matter by OMB.

We are also concerned with the cancellation. We don't know whether it's a hospital or a nursing home. We are deeply concerned with the deferrals because, as you know and we know, the repeated deferrals become cancellations because they become fiscally unpalatable.

In my prepared statement I point out that in 1972 a VA hospital was built in San Diego with 811 beds at a cost of $40.3 million. Five years later in Los Angeles, an 820-bed hospital cost the VA $87 million. In Minneapolis for a similar sized hospital, we are now talking about $280 million or more dollars.

Mr. Chairman, one of the recommendations of the GAO report of last December, entitled "Opportunity to Reduce the Cost of Building VA Medical Facilities," was that the construction time of VA facilities could be reduced by as much as 15 months and perhaps 11.6 percent by extending the advance planning fund to allow the VA to contract for final design while Congress reviews projects. As stated in my testimony last April, this suggestion is worthy of serious consideration. Subsequently, I have been advised that extending the advance planning fund would require legislative action. If this be the case, appropriate action should be taken by this subcommittee.

Although the advance planning fund is a line item in the VA budget, Mr. Chairman, it is one perhaps to which we pay too little attention. For fiscal year 1983, the VA advised us they needed $5 million more for this fund than it received. If the APF is cut below the required amount, construction is delayed proportionately since, obviously, it cannot go ahead without construction plans. This is an easy sum for budget cutters to zero in on, because it cannot readily be identified as delaying a specific construction project.

This concludes my testimony, Mr. Chairman. I would like to say in parting that, speaking on behalf of the commander in chief of the Veterans of Foreign Wars, James R. Curio, and our Washington office staff, we are going to miss you not being in Congress in January, and we are going to miss you not being on the committee; we are going to miss you not being on the committee; we are going to miss you not being chairman of this subcommittee, and we wish you well in your future endeavors.

[The statement of Mr. Schwab appears at p. 388.]

Mr. MOTTL. Thank you very much, Mr. Schwab. I certainly appreciate that.

Mr. Casteel, do you have a comment?

Mr. CASTEEL. Yes, I would like to comment on the questions you have raised, and I think the American Legion raised the same questions, on the extension of the advance planning fund to include working drawing designs.

In Mr. Alvarez' prepared statement that we received, in discussing this issue, he says:

> We share the subcommittee's concern with respect to the time it takes to develop a project from inception to execution and are continually looking for a means to reduce this development time. Our review of the design fund issue is still in progress and no final policy decision has been made at this time.

Now, this is dated December 14.

In regard to legislation, Don, if we took this issue up, all we could do is authorize the money for such purposes to be appropriated. We feel that the Appropriations Committee can do this by appropriating the money for advanced planning, including design, if the VA would go to them and ask them to do so. They would have to justify it. They have this committee's attitude and they have the GAO's attitude.

I just wanted to make that comment, Mr. Chairman, before we pass the subject.

Mr. MOTTL. We certainly appreciate that.

Mr. SCHWAB. Thank you.

Mr. MOTTL. Last, but not least, we have the testimony to look forward to of Mr. Gabe Brinsky, who is the national service and legislative director of the AMVETS.

Mr. Brinsky.

STATEMENT OF GABRIEL P. BRINSKY

Mr. BRINSKY. Good morning, Mr. Chairman.

With your indulgence, I would like to express my thanks to you, as chairman of the subcommittee, for the many courtesies you have extended to me in the past. My organization joins with me in expressing its appreciation for the important role you have played in conducting these most vital hearings in the most important area of veterans' benefits. We thank you sincerely on behalf of our veteran constituency. We certainly hope, sir, that you will see your way clear to return to Washington.

Because of the hour, and having utilized all my time in paying homage to the chairman, I will not summarize my testimony and, in lieu thereof, will request that my fully prepared statement be incorporated into the record.

Thank you, sir.

[The statement of Mr. Brinsky appears at p. 396.]

Mr. MOTTL. Thank you very much, Mr. Brinsky. Without objection, it will be inserted in the record.

Thanks again to all of you. You have been just wonderful to work with.

Mr. Casteel, you wanted to have something submitted into the record at this time?

Mr. CASTEEL. Yes, sir. I would like to insert a letter from the chairman of the full committee to the Administrator dated November 18, on the subject that Mr. Edgar brought up this morning on the fiscal year 1983 budget, and the response, signed by Mr. Alvarez, dated December 2, 1982, which in effect says it is embargoed information.

Mr. MOTTL. Without objection, it will be inserted into the record.[1]

Mr. CASTEEL. I would also like to insert this bunch of charts that came from the Veterans' Administration. They were distributed to the hospital directors and the chiefs of staff at a meeting at the Washington Hilton Hotel on November 9, 1982. I would like to call particular attention to pages 22 through 25, which says there is an issue that has been resolved by OMB so hopefully the VA will be able to negotiate this figure down.

Mr. MOTTL. Without objection, these documents will be inserted into the record.[2]

Mr. MOTTL. I want to thank Mr. Egan, Mr. Sommer, Mr. DeGeorge, Mr. Kelly, Mr. Schwab, Mr. Brinsky, and all of our other witnesses for appearing here this morning. It has been a most productive hearing that lays the foundation for a series of oversight activities in the 98th Congress.

Before closing, let me say to all members of the subcommittee that it has been, indeed, an honor and a privilege to have worked with you in this most important area of veterans' medical care.

Political fortunes, being what they are, have destined me to move on, and I want each one of you to know how much I appreciate the hard work you have put into this subcommittee. Keep up the bipartisan nature of this important work and I feel confident that the American veteran will be well served.

I want to also express my appreciation to the service organizations, to you gentlemen representing these fine organizations. All of you have been straightforward with this committee and it has certainly been of immeasurable value to our deliberations, all of the testimony you have provided on the many issues that we have taken up. To all of you, many thanks.

Also, I want to express my deep appreciation to the staff, to Ralph Casteel, to Bea, to Chuck, to Brian. You people have been wonderful to work with and you couldn't have a better staff.

I also would like to express my appreciation to Paul, to Rufus, to Vance, to Frank, to Mack, everybody else on this full committee and the subcommittee. You are wonderful people and I wish them all well and a lot of happiness and prosperity and health in their future endeavors. I want to wish a happy holiday season to all of you.

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[1] See p. 280.

[2] See p. 255.

If there is no further business to be brought before the subcommittee, we will stand adjourned. Thank you all.

[Whereupon, at 11:45 a.m., the subcommittee was adjourned.]

APPENDIX

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D. C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:00 a.m., EST.
Wednesday, December 8, 1982

STATEMENT OF
ROBERT A. PETERSON, SENIOR ASSOCIATE DIRECTOR
HUMAN RESOURCES DIVISION

BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ON

THE VETERANS ADMINISTRATION'S
MEDICAL CONSTRUCTION PROGRAM

Mr. Chairman and Members of the Subcommittee, I am pleased to be here this morning to discuss the views of the General Accounting Office on the medical construction program of the Veterans Administration. Our work has generally dealt with three of the most important issues of any medical construction project: Is the the project justified? How big should it be? Can it be built for less? I would like to review for you several reports we have issued over the past 5 years and then discuss our current audit of VA's construction program.

We have recently issued two reports on the planning criteria and processes VA uses to justify proposed nursing home construction projects.

In October 1981 we reported that VA had not been effectively planning and coordinating the construction or use of VA, State home, and community nursing homes. We concluded that VA and State home facilities may be built in areas having too many community or State nursing home beds, while not enough beds may be available in other areas to meet VA's anticipated needs. We recommended that the Administrator establish, in coordination with State and local health planning agencies and the National Association of State Veterans Homes, more realistic medical district plans for the construction and/or use of VA, community, and State nursing homes to provide care to veterans. ("State Veterans' Homes: Opportunities To Reduce VA and State Cost and Improve Program Management," HRD-82-7, Oct. 22, 1981.)

We reiterated and expanded on that recommendation in our September 1982 report to the Administrator which concluded that VA did not adequately consider local conditions or less costly alternatives before building new nursing homes. Specifically, we found that VA

--justified new nursing home construction using national demographic and needs projections with little input about the characteristics and resources of the medical districts or the medical centers' primary service areas;

--did not adequately consider the option of providing more nursing home care in community nursing homes by expanding its use of existing legislative authority to contract for care; and

--did not adequately consider converting, renovating, or changing the mission of its existing VA facilities to help meet the need for more nursing home beds.

We were concerned that VA's revalidation of construction projects, recommended by the Administrator in February 1982, was not going to critically review the criteria VA had been using to justify nursing home construction projects. We were also aware of VA's move to decentralized planning (MEDIPP--medical district initiated planning process) and were concerned that the districts' continued reliance on VA's existing criteria could result in an unnecessarily expensive response to projected veterans' nursing home care needs, with over-supplies of nursing home beds in some geographical areas and shortages in others. We recommended that the Administrator ensure that VA nursing home construction projects be proposed to the Congress only after a thorough consideration of less costly options. ("VA Should Consider Less Costly Alternatives Before Constructing New Nursing Homes," HRD-82-114, Sept. 30, 1982.)

Mr. Chairman, in December 1981 we reported to you and this Subcommittee about an opportunity to reduce the time VA takes to complete medical facility construction projects, thus minimizing the effects of inflation on overall project costs. At your request, we reviewed the reasons for cost growth in VA's medical facility construction program, the reason for large numbers of changes to design and construction contracts, and the cost these changes added to projects. We reviewed several recently completed projects--hospitals, nursing homes, and research and education buildings. We identified changes during the design phase which eventually increased the projects' cost by 18.8 percent and changes made while the projects were under construction which added 6.9 percent to the construction contracts.

We noted, however, that VA's construction program has changed significantly since the projects we reviewed were being designed and constructed. Congressional concerns about cost growth in VA's major construction program prompted (1) the Congress to enact legislation to control the growth of VA projects beyond their original cost estimates and (2) VA to create the Advanced Planning Fund to enable it to provide the Congress better cost estimates. Although it was too soon to fully evaluate the effectiveness of these actions during our audit, we believed they should enable the VA to submit better cost estimates to the Congress and should provide an upper limit cost control on approved projects.

The time it takes to complete medical facility construction projects could be reduced by up to 15 months by extending the

Advanced Planning Fund to allow VA to contract for final design while the Congress reviews the projects. This could reduce overall project costs by minimizing the effects of inflation; however, there would be the added risk that, if the Congress did not approve or fund a project so designed, the final design costs could be wasted. Whether the changes should be made rests largely on the confidence the Congress has in VA's ability to identify and prioritize its construction requirements. ("Opportunity To Reduce the Cost of Building VA Medical Facilities," HRD-82-28, Dec. 30, 1981.)

In May 1977 we recommended that VA adopt a computer-based model which we developed to determine the acute care bed needs of new and replacement hospitals. The basic problem had been that VA's health care system centered around the acute care hospital. Because VA's former planning model relied on past experience in determining what was needed, estimates of hospital size tended to reflect the inefficient system of the past. Moreover, VA's planning model did not recognize in a precise way expected changes in the size and age mix of the veteran population.

We developed a new model which analyzed past practices and determined what different degrees of care should have been provided. Application of this model to projected veterans' population data showed that a mix of medical facilities different from that proposed in 1976 was needed to permit new replacement hospitals to have a range of health care options consistent with modern medical practice. ("Review of Veterans Administration's Methodology for Determining Hospital Bed Size," HRD-77-104, May 20, 1977. VA's bed sizing methodology was also discussed in the following reports: "Constructing New VA Hospital in Camden, New Jersey, Unjustified," HRD-78-51, Feb. 6, 1978, and "Inappropriate Number of Acute Care Beds Planned by VA for New Hospitals," HRD-78-102, May 17, 1978.) Since then we have been working closely with the VA to improve the current model and expand its capability. Two of our staff are serving in an advisory capacity to VA in its effort to upgrade and refine the model. Just last month, they attended a conference at the VA medical center in Gainesville, Florida, to provide feedback to VA researchers working with the model.

Finally, in March 1981, we reported that VA's criteria for surgical facilities in new or replacement hospitals was resulting in too many operating rooms. We noted that the VA guidelines failed to consider that some occupants of surgical beds do not undergo surgery, and the time needed to perform a surgical procedure varied according to the type of surgery and the surgeon's experience. VA disagreed with some of the specifics of our report but agreed to develop a new model, similar to the one we proposed. ("Better Guidelines Could Reduce VA's Planned Construction of Costly Operating Rooms," HRD-81-54, May 3, 1981.)

We have one audit currently underway which addresses the issues of the cost of VA's medical construction program. We have been concerned about the growing disparity between the cost of constructing VA and community nursing home beds. The four nursing home construction projects approved in VA's fiscal year 1983 budget will provide 360 beds at a cost of about $35.5 million, or about $98,500 per bed. Community nursing homes are reportedly being constructed for under $30,000 per bed. Our preliminary objectives, therefore, are to more accurately determine the cost of constructing VA and community nursing homes and then to isolate specific items which cause the VA beds to be so much more expensive.

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Mr. Chairman, this completes my prepared statement. We will be happy to answer any questions you have.

GAO'S OBSERVATIONS ON EXTENT AND COST OF CHANGE ORDERS TO VA MEDICAL FACILITY CONSTRUCTION CONTRACTS

On December 30, 1981, we reported to the Chairman, Subcommittee on Hospitals and Health Care of the House Committee on Veterans' Affairs, that the Veterans Administration (VA) frequently changed the scope of design and construction contracts on the 10 medical facility construction projects we reviewed. During testimony on December 14, 1982, the Subcommittee Chairman asked us to provide recommendations on how VA can better control the extent and cost of the changes. In this paper we will summarize data presented in our 1981 report, provide more recent data gathered by VA, compare VA's experience with that of private hospital construction firms, describe VA's policies and procedures for approving and funding changes for design and construction contracts, and offer some matters for the Subcommittee's consideration.

VA'S EXPERIENCE WITH CHANGE ORDERS

Our report to the Subcommittee, "Opportunity to Reduce the Cost of Building VA Medical Facilities," (HRD-82-28, Dec. 30, 1981) was based on our review of 10 new major construction projects completed from 1972 through 1978. We found that VA modified the 10 design contracts1/ 198 times, increasing their

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1/ VA had 10 design contracts on the 10 projects we reviewed; although VA designed the Long Beach nursing home entirely in-house, the Los Angeles replacement hospital was designed in two phases, each with a separate contract.

cost 18.8 percent. VA also changed the 11 construction contracts[2] 1,847 times, increasing their cost 6.9 percent. The following table shows the effects of those change orders on each project.

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[2] VA had 11 construction contracts on the 10 projects we reviewed--the Los Angeles replacement hospital was built in two phases, each with a separate construction contract.

Project	Original design contract amount	Modifications		Percent increase	Original construction contract amount	Change orders		Percent increase
		Number	Amount			Number	Amount	
Hospitals								
Tampa	$ 665,000	24	$130,725	19.7	$ 19,557,300	186	$2,105,094	10.8
San Antonio	995,000	30	286,731	28.8	31,993,000	249	1,986,054	6.2
San Diego	1,258,770	29	190,747	15.2	34,523,000	318	739,254	2.1
Los Angeles								
Phase I	497,970	16	181,877	36.5	12,617,500	23	1,883,278	14.9
Phase II	2,499,938	25	211,831	8.5	59,333,000	368	5,726,623	9.7
Nursing Homes								
Jackson	152,237	5	14,586	9.6	3,008,000	39	48,352	1.6
Phoenix	272,274	24	34,984	12.8	3,754,000	97	29,240	0.8
Sepulveda	230,835	6	3,693	1.6	3,080,579	38	22,827	0.7
Long Beach	(DESIGNED IN-HOUSE)				2,812,890	97	114,994	4.1
Other								
Houston	309,700	7	410	0.1	4,460,000	86	154,983	3.5
Phoenix	509,600	32	334,354	65.6	17,970,000	346	524,640	2.9
Total	$7,391,324	198	$1,389,938	18.8	$193,109,269	1,847	$13,335,289	6.9

Not all change orders increased the cost of construction. During the Los Angeles replacement hospital construction project, for example, VA had 391 change orders; 314 increased the construction contracts cost, 66 lowered the cost, and 11 had no effect. The data presented for each project, therefore, are the net amounts of all change orders.

In an internal study completed in May 1982, VA examined 55 recently completed projects--major and minor projects, new construction and renovation--and found that change orders amounted to about 3.3 percent of total cost. Included in this analysis are 10 projects which match the criteria we applied in our review--major, new construction projects. VA experienced a change order rate of about 2.2 percent for these projects. Although these rates are based on total project cost and not just the construction contract, we believe they indicate that VA has improved its control over change orders.

We found that about 61 percent of the change orders issued on the projects we reviewed (about 73 percent of the dollar amount) were initiated by VA to provide for particular features it wanted within the facility; about 39 percent (or about 27 percent of the dollar amount) were to correct design errors or omissions; and less than one percent were for uncontrollable acts, such as strikes or floods. VA analyzed 14 of the 55 projects in its study and found that only about 25 percent (about 36 percent of the dollar amount) were VA-initiated; about 54 percent (about 53 percent of dollar amount) were for design errors, and about 21 percent (about 11 percent of the dollar amount) were for uncontrollable acts.

In 1975 we recommended that VA strengthen its procedures for (1) evaluating and documenting architect/engineer (A/E) firms' performance and (2) referring appropriate cases for legal action to recover the cost of the change orders from the A/E firm responsible for the design error. (See report to the Chairman, Subcommittee on Housing and Urban Development, Space Science, and Veterans, Senate Committee on Appropriations, MWD-75-100, June 20, 1975.) VA has a memorandum of "Policies and Procedures for Evaluation of Architect-Engineer Project Performance and for Determining Architect-Engineer Liability for Design and Construction Services Deficiencies." According to officials in VA's General Counsel and Office of Construction, VA has on several occasions recovered some of the cost of change orders caused by design errors or omissions from the responsible A/E firm, usually through negotiation. During fiscal years 1978 through 1982, VA Central Office has litigated only one case for this purpose.

VA'S POLICIES AND PROCEDURES FOR APPROVING AND FUNDING CHANGES TO CONSTRUCTION CONTRACTS

Change orders alter the contractual agreement regarding scope of work, cost, and/or completion date between VA and the contractor. VA change orders involve sole source negotiation, which is the least desirable method of Government procurement since it is generally accepted that the Government pays a higher cost when competition is absent. To limit these situations, VA's construction policies require that change orders not be used when the work can be handled by separate contract:

> "It is the intent of the Federal Procurement Regulations and existing statutes that the Veterans Administration's construction be accomplished by a contract awarded to the lowest responsible bidder. To comply with these directives, no work will be accomplished by change order unless it cannot be accomplished without interference with the present contractor, or the work is such an integral part of the work under the contract that it cannot be accomplished by others.* * *"

If either of these conditions are not present, VA requires that the work be accomplished under a separate contract.

Change orders costing $20,000 or less and adding 20 days or less to the contract time may be approved by VA's resident engineers (field staff). Change orders of $50,000 or less may be approved by VA's project directors (central office staff). Change orders of more than $50,000 must be approved by VA's Assistant Deputy Administrator for Construction. To further control the cost of change orders of $1,000 or more, VA requires the contractor's cost proposal be within approximately 10 percent of VA's independent cost estimate.

Funds appropriated by the Congress for VA medical facility construction projects include a contingency amount--5.0 percent for new construction or 7.5 percent for alterations or renovations--to cover change orders. In addition, if the actual construction contract is less than the amount appropriated for that purpose, VA transfers the excess to a Working Reserve Fund. These funds are available to cover change orders in excess of contingency funds, to help fund projects where the construction contract was costlier than had been planned, or to reduce the next year's request for appropriations for major construction projects.

In addition to the control imposed by the availability of working reserve funds, VA cannot increase a project's cost more than 10 percent without getting Congressional approval. During the 1970's, the Congress became increasingly concerned about large cost growth in VA's medical facility construction projects. Public Law 96-22, enacted in June 1979, required that (1) House and Senate Veterans' Affairs Committees approve projects before they can be funded and (2) VA not increase projects' cost by more than 10 percent above the amount approved by the Veterans' Affairs Committees.

As part of a government-wide audit of construction contract change orders, VA's Inspector General recently evaluated the controls over change order processing and the documentation used to support the need and cost of change orders. The Inspector General concluded that

--adequate controls existed over change orders for the construction contracts included in the review,

--necessary policies and procedures had been established and were published in VA manuals and handbooks,

--appropriate reviews of change orders had been established and were adhered to,

--necessary documentation to support the need for change orders was properly developed and maintained in contract files,

--contracting officers at central office and the two medical centers included in the review appropriately used available technical personnel to assist them in administering construction contracts and making decisions about contract change order approvals,

--adequate funds were available to cover the cost of approved change orders,

--fund availability was certified prior to approving change orders,

--government inspectors insured that work was accomplished in accordance with plans and specifications and performed technical reviews and evaluations of contractor proposals, and

--negotiations were held to insure that the government paid a fair price for contract change orders.

CHANGE ORDER EXPERIENCE OF NON-FEDERAL HOSPITAL CONSTRUCTION FIRMS

During our review, we met with senior officials of several major hospital organizations to discuss their techniques for controlling the cost of building new facilities. The organizations used various techiques to minimize change orders. Some had policies that change orders were only to be used in the case of design errors or omissions. Some required any program change to be approved at very high levels in the organization (the president in one corporation). Others established a contingency fund--either a percentage of the contract or a flat amount.

The cost of change orders experienced or expected varied among the groups. One corporation stated that its change order cost experience on three hospitals ranged from 0.3 percent to 5.6 percent. Another stated a range of 2.5 to 8.0 percent. Five groups set change order cost goals ranging from less than 1 percent to 3 percent of construction costs.

Although all organizations did not provide us with complete data on change orders, data we were able to obtain indicate that the actual change order rate varied, but was not out of line with that experienced by VA:

Organization	Number of projects	Original construcction contract amount	Change orders Number	Change orders Amount	Percent increase
National Medical Enterprises, Inc.	8	$ 34,155,005	(a)	$2,654,529	7.8
Beverly Enterprises,	4	6,416,914	49	257,332	4.0
Lutheran Hospitals and Homes Society of America	4	19,965,521	(a)	(282,066)	(1.4)
Health Central, Inc.	1	5,143,585	20	14,648	0.3
United Hospital	1	12,896,487	(a)	910,879	7.1
Total	18	$ 78,577,512	(a)	$3,555,322	4.5

(a) - Data not made available to GAO.

CONCLUSIONS

VA expects change to construction contracts. Its standard contract gives it the right to make any change within the scope of the contract. It has adopted detailed procedures on how change orders are to be handled. It builds a contingency amount into every project's estimated cost. It maintains a Working Reserve Fund to pay for change orders.

The Congress also expects change orders. It funds projects based on cost estimates which include the 5.0 or 7.5 percent contingency. It allows VA to reprogram funds to pay for change orders. It allows a project's cost to grow up to 10 percent of the amount approved by the Veterans' Affairs Committees.

It is difficult to evaluate whether VA has used change orders excessively. There is an undeniable need for flexibility when constructing medical facilities, especially complex projects such as new or replacement hospitals. However, there are no standards on the extent that changes are acceptable, and reliable information is not generally available on the experience of the private sector. VA's experience does not appear to be significantly out of line with its internal expectation (5 percent contingency) or congressional limitations (10 percent cost growth). Based on VA's reported improvement in its change order rate since our review, the soundness of its procedures for approving change orders (as reported by VA's Inspector General), and the fact that VA's experience is not out of line with that reported by private hospital construction organizations, it appears that VA has improved its control over the extent and cost of change orders.

We are concerned, however, at the apparent increase in the proportion of change orders VA has made because of design errors and uncontrollable acts. Because the proportion of change orders caused by design errors has increased significantly (from 39 to 54 percent of the number and 27 to 53 percent of the dollar value), we believe the Subcommittee should require VA to (1) determine whether the Office of Construction has been following its procedures for determining the liability of and recovering funds from responsible A/E firms and (2) report to the Subcommittee with its results of this evaluation. We also believe that because the proportion of change orders caused by uncontrollable acts has also increased substantially (from less than one percent in our sample to 21 percent of the number and 11 percent of the dollar amount in VA's sample), the Subcommittee should require VA to review these change orders to be sure they have been properly classified.

TESTIMONY OF CONGRESSMAN BILL FRENZEL
before the
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS

December 14, 1982

My purpose in submitting testimony before this Subcommittee is to express again my desire that the VAMC is approved for funding in FY 1984. I believe that the hurdles the project faced in the past have been overcome. After many setbacks, and the dismay of seeing several other projects receive funding before the Minneapolis VAMC, despite it having been the VA's number one construction priority for several years, this SUbcommittee and the full Committee recommended that the project be funded in FY 1983. Unfortunately, the Senate did not fund the hospital, and conferees on the HUD-Independent Agencies Appropriations bill decided to delete funding. However, Senator ALan SImpson, Chairman of the Senate Veterans Affairs Committee, has indicated that he supports funding for the Minneapolis hospital in FY 1984, as does Senator Jake Garn, Chairman of the Subcommittee on HUD-Independent Agencies Suncommittee of the Senate Appropriations Committee. Although funding in FY1983 would have been preferable, an early commitment for FY1984 funding will allow the VA to begin the early stages of construction in a timely manner.

Mr. Chairman, nothing has changed since last spring when several of my colleagues joined me in testifying before this Subcommittee in favor of the Minneapolis VAMC. The present facility is still antiquated, sub-standard, and does not adquately meet the needs of Minnesota-area veterans. Although the hospital benefits from its association with the University of Minnesota medical school and thus has the potential to offer some of the latest medical advances, the supporting facility is so poor that the Minneapolis facility was nontheless ranked as among the three most deficient in the VA system in 1980. Very little, if anything, has been done to improve this ranking.

In addition, I want to emphasize that not only must the replacement hospital be approved, it must also be constructed large enough to adequately serve the veterans of the Upper Midwest who will depend on this new facility for care. Nothing has changed, Mr. Chairman, that would suggest that we should build a smaller facility than that originally authorized for planning purposes in FY 1981. As I am sure all Members of this Subcommittee will recall, a rider to limit the size of the hospital to 649 beds was defeated, and the original recommendation of 845 beds - 120 nursing home beds, 725 acute care beds - was strongly supported. This facility serves 79 counties in five states which contain a growing population of aging veterans. Building a smaller facility on the basis of lo-estimate demand parameters will no doubt save a significant amount of money in the next fiscal year. However, I believe the savings from underbuilding would be overwhelmed by the potential cost of constructing additions in future fiscal years because the veterans' demand exceeded the capacity of the original facility.

It had been suggested, of course, that excess hospital capacity already exists in the Twin City Metropolitan area. I question the applicability of this factor in two regards. First, it is clear that the mission of the VA hospital system and non-veteran hospitals are quite different. Because of this, I do not believe VA hospital beds should be treated as if they are in the same pool as other hospital beds. More important, however, is the fact that the service area of the Minneapolis VA hospital is far greater than the Twin City metro area. I have yet to see figures demonstrating excess VA capacity in Medical District 18, the area served by the Minneapolis VA hospital.

Mr. Chairman and SUbcommittee Members., I thank you for allowing me to provide testimony on this important matter, and would also like to thank you for your continued efforts on behalf of the Nation's veterans.

STATEMENT OF EVERETT ALVAREZ, JR.
DEPUTY ADMINISTRATOR OF VETERANS' AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
DECEMBER 14, 1982

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I AM PLEASED TO APPEAR BEFORE YOU TO DISCUSS THE VETERANS ADMINISTRATION'S MEDICAL FACILITY PLANNING AND CONSTRUCTION PROGRAM.

AS YOU KNOW, OUR FY 1984 CONSTRUCTION AUTHORIZATIONS REQUEST AND PROPOSED FY 1984 MEDICAL FACILITIES CONSTRUCTION PROGRAM WILL SOON BE SUBMITTED TO YOU FOR REVIEW. ALTHOUGH THE SPECIFICS OF OUR FY 1984 CONSTRUCTION BUDGET REQUEST CANNOT BE DISCUSSED AT THIS TIME, I AM PLEASED TO ADVISE YOU THAT OUR FY 1984 REQUEST REPRESENTS THE LARGEST CONSTRUCTION BUDGET EVER PROPOSED BY THE VETERANS ADMINISTRATION.

THE VA RECOGNIZES AND IS STRONGLY COMMITTED TO THE OBLIGATION WE HAVE TO PROVIDE A MODERN, COMPREHENSIVE, AND INDEPENDENT HEALTH CARE DELIVERY SYSTEM WHICH OFFERS ELIGIBLE VETERANS

ACCESS TO THE HIGHEST QUALITY HEALTH CARE. LIKE THE VETERAN POPULATION, HOWEVER, THE VA'S HEALTH CARE FACILITIES ARE AGING. OVER HALF (53%) OF THE VA'S AUTHORIZED HOSPITAL BEDS ARE LOCATED IN VA FACILITIES WHICH ARE MORE THAN 30 YEARS OLD. MANY ADVANCES HAVE BEEN MADE IN HEALTH CARE TECHNOLOGY, AND AS THE VETERAN POPULATION AGES, THE HEALTH CARE NEEDS OF THAT POPULATION CHANGE. IF WE ARE TO CONTINUE TO MEET OUR STATUTORY RESPONSIBILITIES TO PROVIDE COMPREHENSIVE, QUALITY HEALTH CARE TO THE VETERAN POPULATION, INCREASED CONSTRUCTION RESOURCES WILL BE NECESSARY TO MEET OUR MEDICAL FACILITY NEEDS. TOWARD THIS END, THE BUDGET AUTHORITY FOR VA MAJOR AND MINOR CONSTRUCTION PROJECTS WAS INCREASED BY OVER $70 MILLION BETWEEN FY 1982 and FY 1983.

AS AN IMPORTANT AND RELATED ISSUE, CONGRESS HAS INDICATED THAT THE VETERANS ADMINISTRATION SHOULD IMPROVE THE CRITERIA USED TO DETERMINE THE PRIORITY OF VA HOSPITAL CONSTRUCTION AND DEVELOP IMPROVED LONG-RANGE MEDICAL FACILITY PLANNING TECHNIQUES.

WITHIN THE LAST FEW YEARS, THE VA HAS UNDERTAKEN SIGNIFICANT STEPS TO BE RESPONSIVE TO SUCH CONGRESSIONAL DIRECTIVES AND HAS INSTITUTED A BROAD ARRAY OF INITIATIVES TO MORE EFFECTIVELY DETERMINE AND RANK OUR CONSTRUCTION NEEDS ON A SYSTEMWIDE BASIS. A COMPREHENSIVE DELINEATION OF THESE INITIATIVES WAS OUTLINED IN A RECENT LETTER TO CHAIRMAN GARN AND CHAIRMAN BOLAND. A COPY ALSO WAS PROVIDED TO THIS SUBCOMMITTEE AND IS ATTACHED AS AN ADDENDUM TO THIS STATEMENT.

IN TERMS OF HEALTH CARE CONSTRUCTION PLANNING, WE BELIEVE THAT THE MEDICAL DISTRICT INITIATED PROGRAM PLANNING PROCESS (MEDIPP) HOLDS GREAT PROMISE AS A DECENTRALIZED PROCESS WHICH WILL BETTER AID US IN IDENTIFYING AND RANKING CONSTRUCTION NEEDS ON A MEDICAL DISTRICT SPECIFIC BASIS. MEDIPP IS STILL IN ITS INITIAL STAGE OF IMPLEMENTATION AND WILL NO DOUBT REQUIRE FURTHER REFINEMENT. NEVERTHELESS, WE ANTICIPATE THAT THE DATA GENERATED BY MEDIPP WILL PROVIDE CENTRAL OFFICE PLANNERS WITH A MUCH IMPROVED ASSESSMENT OF VETERAN HEALTH CARE NEEDS THAT IS BASED ON A SOLID DEMOGRAPHIC FOUNDATION AND RESPONSIVE TO

LOCAL CONDITIONS AND VARIANCES.

ONE PARTICULAR AREA OF EMPHASIS IN OUR FACILITY PLANNING IMPROVEMENTS IS TO ENSURE THAT THE DATA UPON WHICH OUR FACILITY PLANNING AND CONSTRUCTION DECISIONS ARE FORMULATED ARE ACCURATE AND RELIABLE. RECENT VA INITIATIVES IN THIS AREA INCLUDE THE DEVELOPMENT AND SUCCESSFUL TESTING OF A COMPREHENSIVE METHODOLOGY FOR UNIFORMLY ASSESSING THE PHYSICAL PLANT CONDITION OF VA MEDICAL FACILITIES, IMPROVEMENTS IN THE DEVELOPMENT AND APPLICATION OF VA HEALTH CARE FACILITY SPACE PLANNING CRITERIA, AND A RESEARCH ANALYSIS OF THE SPACE AND FUNCTIONAL DEFICIENCY IDENTIFICATION (SFDI) SYSTEM TO IMPROVE AND REFINE IT IN ORDER THAT IT MAY BE BETTER UTILIZED AS AN EVALUATIVE TOOL AND BE FULLY INTEGRATED INTO OUR FACILITY PLANNING PROCESS. THROUGH MEDIPP, WE ALSO WILL BE ABLE TO SUPPLEMENT OUR PLANNING EFFORT WITH LOCAL INFORMATION ON ACTUAL AND PROJECTED VETERANS' NEEDS FOR VARIOUS HEALTH CARE PROGRAMS. TO ADVANCE THIS COMPONENT OF MEDIPP, THE CHIEF MEDICAL DIRECTOR, IN JULY 1982, PROVIDED HEALTH CARE PLANNERS

IN EACH OF OUR 28 MEDICAL DISTRICTS WITH TECHNICAL GUIDANCE FOR PREPARING HEALTH CARE NEEDS ASSESSMENTS IN A MORE COMPREHENSIVE MANNER THAN WE HAVE HAD HERETOFORE.

MR. CHAIRMAN, I HAVE ONLY TOUCHED ON SOME OF THE PLANNING INITIATIVES WHICH WE HAVE UNDERTAKEN, BUT ALL OF THEM ARE DIRECTED TOWARD IMPROVING THE VA'S STRATEGIC PLANNING SYSTEM FOR HEALTH CARE FACILITIES. I BELIEVE THAT THESE ARE SIGNIFICANT AND SUBSTANTIVE INITIATIVES, AND I COMMEND THE CHIEF MEDICAL DIRECTOR AND THE HEAD OF THE OFFICE OF CONSTRUCTION, AS WELL AS THEIR STAFFS, FOR THE DEDICATION AND EFFORT WHICH PRODUCED THEM. ONCE THESE INITIATIVES, AND OTHERS WHICH CONTINUE TO EVOLVE, HAVE BEEN FULLY IMPLEMENTED, OUR ABILITY TO PERFORM COMPREHENSIVE, LONG-RANGE FACILITY PLANNING, BASED ON OBJECTIVE DATA, WILL BE GREATLY ENHANCED.

PENDING FULL IMPLEMENTATION OF THESE IMPROVEMENTS TO OUR HEALTH CARE PLANNING PROCESS, WE INITIATED A SPECIAL INTERIM EFFORT DIRECTED TOWARD ENSURING, PRIOR TO ACTUAL CONSTRUCTION

FUNDING, THAT THE MAJOR CONSTRUCTION PROJECTS WE WERE CONSIDERING FOR FY 1984 WERE FULLY RESPONSIVE TO VETERAN HEALTH CARE NEEDS; APPROPRIATELY SIZED, SCOPED AND LOCATED; AND BASED ON CURRENT WORKLOAD DATA AND ACCURATE SPACE AND FUNCTIONAL CRITERIA. THIS CONSTRUCTION PROGRAM REVIEW WAS AN EXTENSION AND INTENSIFICATION OF OUR PROJECT REVIEW PROCESS, UNDERTAKEN AT A TIME WHEN SOME CONCERNS HAD BEEN EXPRESSED WITH REGARD TO THE VA'S PLANNING AND CONSTRUCTION PROGRAM AND PENDING IMPLEMENTATION OF THE PLANNING IMPROVEMENTS WE HAD INITIATED IN RESPONSE TO THOSE CONCERNS.

IN TERMS OF THE PROCESS USED FOR OUR REVIEW, PROJECTS WERE SELECTED FOR REVIEW IF THEY COULD POSSIBLY BE READY AT THE TIME OF OUR FY 1984 BUDGET CONSIDERATION. THE LIST OF PROJECTS WHICH POTENTIALLY COULD MEET THIS STANDARD WAS DEVELOPED BY THE DEPARTMENT OF MEDICINE AND SURGERY (DM&S), AND THE OFFICE OF CONSTRUCTION (O/C), AND EVENTUALLY TOTALED 57 PROJECTS. BOTH O/C AND DM&S ADVISED AT THE OUTSET THAT PROJECT DEVELOPMENT SCHEDULE DELAYS AND/OR DESIGN PROBLEMS WERE

PROBABLE ON SEVERAL PROJECTS, AND THIS WOULD PRECLUDE THEM FROM BEING POSSIBLE CANDIDATES FOR THE REVIEW PROCESS. ALSO, SOME OF THE PROJECTS ON THE LIST WERE ALREADY UNDERGOING REDESIGN AND WERE INCLUDED ONLY BECAUSE THERE WAS A POSSIBLE CHANCE THAT THE REDESIGN COULD BE COMPLETED IN TIME.

THESE 57 PROJECTS WERE ASSIGNED TO ONE OF SIX MULTI-DISCIPLINARY TEAMS COMPOSED OF A REPRESENTATIVE FROM DM&S, O/C AND THE VA'S OFFICE OF BUDGET AND FINANCE. THE TEAMS WERE ASSIGNED THEIR LIST OF PROJECTS ON MARCH 25, 1982, AND WERE PROVIDED WITH GUIDANCE TO COMPREHENSIVELY REVIEW EACH PROJECT, INCLUDING A SITE VISIT, IF NECESSARY, USING THE MOST CURRENT PLANNING DATA, MODELS AND METHODOLOGIES AVAILABLE IN THE AGENCY. THEY WERE INSTRUCTED TO REVIEW THE PROJECT DEVELOPMENT SCHEDULE TO DETERMINE IF THE PROJECT COULD REALISTICALLY BE EXPECTED TO BE READY FOR FY 1984 CONSIDERATION. THEY WERE FURTHER INSTRUCTED TO COMPARE PRIOR WORKLOAD DATA WITH CURRENT WORKLOAD PROJECTIONS FOR EACH PROJECT; TO REVIEW THE PROJECT'S DATA PACKAGE; TO EXAMINE THE PROJECT'S SPACE REQUIREMENTS; AND

TO REVIEW AVAILABLE DESIGN DRAWINGS FOR THE PROJECT, COORDINATION OF THE PROJECT WITH OTHER PLANNED CONSTRUCTION, AND BACKFILL PLANS IF THE PROJECT WOULD RESULT IN SPACE BEING VACATED.

THE RESULTS OF THE TEAMS' REVIEWS WERE PRESENTED TO A STEERING COMMITTEE COMPOSED OF THE DEPUTY ADMINISTRATOR, THE CHIEF MEDICAL DIRECTOR, THE ASSOCIATE DEPUTY ADMINISTRATOR FOR LOGISTICS, THE ASSISTANT DEPUTY ADMINISTRATOR FOR CONSTRUCTION; THE ASSISTANT DEPUTY ADMINISTRATOR FOR BUDGET AND FINANCE, AND THE GENERAL COUNSEL, FOR REVIEW, DISCUSSION, AND RESOLUTION.

BY JUNE 27, THE STEERING COMMITTEE COMPLETED ITS DELIBERATIONS. THE CHIEF MEDICAL DIRECTOR AGAIN REVIEWED THOSE PROJECTS AND RANKED THEM IN THE DEPARTMENT'S PRIORITY ORDER FOR THE ADMINISTRATOR'S CONSIDERATION.

MR. CHAIRMAN, THE SPECIAL REVIEW EFFORT UNDERTAKEN OF OUR MAJOR CONSTRUCTION PROGRAM WAS AN INTERNAL AGENCY EFFORT BY VA STAFF TO ENSURE QUALITY CONTROL AND PRUDENT EXPENDITURE

OF TAX DOLLARS. WE BELIEVE THAT OUR REVIEW MET THESE GOALS AND THAT THIS SUBCOMMITTEE WILL SHARE THE FULL CONFIDENCE WE HAVE AS A RESULT IN OUR MAJOR CONSTRUCTION PROGRAM.

THE REVIEW EFFORT ALSO WAS A SPECIAL INTERIM RESPONSE TO A SPECIAL INTERIM TIME. WE ARE NOW BUILDING ON THE TYPE OF COMPREHENSIVE REVIEW PROCESS USED AND INTEGRATING THE BENEFICIAL LESSONS OF THAT REVIEW INTO THE LOGIC OF OUR NORMAL FACILITY PLANNING AND PROJECT DEVELOPMENT SYSTEM. THE CHIEF MEDICAL DIRECTOR AND HIS STAFF ARE CURRENTLY WORKING ON SPECIFIC IMPROVEMENTS IN OUR NORMAL PROJECT DEVELOPMENT PROCEDURES WHICH WILL INCORPORATE THESE REFINEMENTS IN THE EXISTING PROCESS. WITH THESE IMPROVEMENTS, WE BELIEVE THAT OUR NORMAL PROJECT DEVELOPMENT PROCESS WILL OFFER THE SAME LEVEL OF ASSURANCE REGARDING PROJECT JUSTIFICATION AS DID THE SPECIAL PROCEDURES PREVIOUSLY INSTITUTED FOR OUR MAJOR CONSTRUCTION PROGRAM REVIEW.

MR. CHAIRMAN, IN YOUR TRANSMITTAL LETTER OF NOVEMBER 15, 1982, ADVISING THE ADMINISTRATOR OF THIS HEARING, YOU ALSO REQUESTED AN UPDATE ON THE STATUS OF PROJECTS FOR WHICH FUNDS HAVE BEEN APPROPRIATED, AS WELL AS COMMENT ON A DECEMBER 30, 1981, GENERAL ACCOUNTING OFFICE (GAO) REPORT AND DISCUSSION OF THE FIVE-YEAR MEDICAL FACILITY CONSTRUCTION PLAN FOR FY 1983-1987.

I BROUGHT WITH ME THIS MORNING THE HEAD OF THE OFFICE OF CONSTRUCTION TO ASSIST ME IN PROVIDING YOU WITH A STATUS REPORT ON AUTHORIZED AND FUNDED CONSTRUCTION PROJECTS. HE WILL BE HAPPY TO RESPOND TO YOUR QUESTIONS.

IN TERMS OF THE DECEMBER 1981 GAO REPORT (HRD-82-28), "OPPORTUNITY TO REDUCE THE COST OF BUILDING VA MEDICAL FACILITIES," WE ARE GIVING SERIOUS CONSIDERATION AND STUDY TO THE POSSIBILITY OF INAUGURATING A DESIGN FUND FOR WORKING DRAWINGS, SIMILAR TO THE CURRENT ADVANCE PLANNING FUND (APF) FOR PRELIMINARY PLANS. SUCH A FUND COULD REDUCE PROJECT DEVELOPMENT TIME BY 12 to 18 MONTHS, WHICH NOW IS BASICALLY

THE TIME BETWEEN COMPLETION OF PRELIMINARY PLANNING UNDER THE CURRENT APF PROCESS AND THE TIME CONGRESS APPROPRIATES FUNDS FOR WORKING DRAWING DESIGN. WE SHARE THE SUBCOMMITTEE'S CONCERN WITH RESPECT TO THE TIME IT TAKES TO DEVELOP A PROJECT FROM INCEPTION TO EXECUTION, AND ARE CONTINUALLY LOOKING FOR MEANS TO REDUCE THIS DEVELOPMENT TIME. OUR REVIEW OF THE DESIGN FUND ISSUE IS STILL IN PROGRESS AND NO FINAL POLICY DECISION HAS BEEN MADE AT THIS TIME.

AS WE NOTED IN RESPONSE TO A QUESTION AT THE APRIL 1 HEARING, WE ALSO FEEL THAT INSTITUTION OF THE ADVANCE PLANNING FUND (APF) PROCESS HAS BEEN BENEFICIAL IN ALLOWING EARLIER RESOLUTION OF PROGRAMMATIC NEEDS IN PROJECT DEVELOPMENT. THIS, IN TURN, HAS ACTED TO CORRECT SOME PREVIOUS PROBLEMS WE HAVE EXPERIENCED ON EARLIER PROJECTS IN TERMS OF PROGRAMMATIC CHANGES AND CHANGE ORDERS DURING DESIGN AND CONSTRUCTION.

WITH REFERENCE TO THE CURRENT FIVE-YEAR MEDICAL FACILITY

CONSTRUCTION PLAN SUBMITTED TO YOU IN JUNE 1982, THIS FIVE-YEAR PLAN IS A PRODUCT OF THE DM&S FACILITY PLANNING PROCESS THROUGH WHICH EACH MEDICAL CENTER UPDATES THEIR FACILITY PLAN ON AN ANNUAL BASIS. THESE INDIVIDUAL FACILITY PLANS ARE REVIEWED AND ADJUSTED AS NECESSARY TO FORM A COHESIVE NATIONAL STRATEGY. EACH MEDICAL CENTER'S FACILITY PLAN DETAILS BOTH THE CONSTRUCTION STRATEGIES AND THE SPECIFIC PROJECTS NEEDED TO SUPPORT THE FACILITY'S PROGRAM MISSION AND LEVELS OF SERVICE. THE IMPLEMENTATION OF THE MEDICAL DISTRICT INITIATED PROGRAM PLANNING (MEDIPP) PROCESS WILL STRENGTHEN THE FACILITY PLANS BY PROVIDING MORE FIRM PROGRAMMATIC PLANS FOR THE DELIVERY OF SERVICE AND THUS A STRONGER FOUNDATION UPON WHICH TO DEVELOP SPECIFIC FACILITY PLANS.

IN ACCORDANCE WITH SECTION 5007 OF TITLE 38, THE FIVE-YEAR MEDICAL FACILITY CONSTRUCTION PLAN ALSO INCLUDES A LISTING OF THE TEN MEDICAL CENTERS WHICH WE CONSIDER MOST IN NEED OF CONSTRUCTION, REPLACEMENT OR MAJOR MODERNIZATION. IN THE

JUNE 1982 FIVE-YEAR PLAN, WE HAVE ADDED THE BALTIMORE METROPOLITAN AREA TO THE LIST. WE CURRENTLY ARE ASSESSING THE NEEDS OF THE FACILITIES IN THE BALTIMORE METROPOLITAN AREA. WE RECOGNIZE MAJOR DEFICIENCIES IN THE EXISTING FACILITIES AND WOULD EXPECT TO COME TO SOME CONCLUSIONS IN THE SPRING, AFTER THE MEDIPP REVIEW HAS BEEN COMPLETED. THE MEDICAL CENTER WHICH APPEARED ON THE PREVIOUS "LIST OF TEN" AND IS NOT ON THIS YEAR'S LIST IS PALO ALTO, CALIFORNIA (MENLO PARK DIVISION). THE NEEDS OF THAT FACILITY ARE BEING MET THROUGH MAJOR CONSTRUCTION FUNDED IN FY 1982.

MR. CHAIRMAN, AND MEMBERS OF THIS SUBCOMMITTEE, WE BELIEVE THAT THE CURRENT FIVE-YEAR PLAN OFFERS A RESPONSIBLE APPROACH TO MEETING THE FACILITY NEEDS OF THE VA HEALTH CARE SYSTEM. WE ALSO RECOGNIZE, HOWEVER, THAT THE PROCESS BY WHICH DM&S DEVELOPS THE FIVE-YEAR PLAN IS UNDERGOING MAJOR IMPROVEMENT AND REFINEMENT, PARTICULARLY IN TERMS OF THE MEDIPP PROCESS.

WE APPRECIATE THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY AND WILL BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

DECEMBER 1 - 1982

Honorable Jake Garn
Chairman, Subcommittee on Housing and
Urban Development and Independent Agencies
Committee on Appropriations
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to take this opportunity to provide you with an update of our efforts to assess the facility needs of VA Medical Centers and to improve our ability to select those most in need of major construction. On October 18, 1982, members of the VA staff met with Mr. Wally Berger and, I am advised, held a fruitful discussion regarding the Committees' concerns in the above areas. In response to Mr. Berger's suggestion, this letter will serve to provide the Committee with current information on our endeavors.

The selection of a Medical Center for inclusion as part of the "List of Ten" is based upon a thorough evaluation of the medical needs of an area and existing deficiencies of a Medical Center. As facilities get older, they develop critical space, physical and functional deficiencies which hinder the delivery of modern health care. When these deficiencies are compounded and require comprehensive correction, total replacement or major modernization of the facility is frequently found to be the most cost-effective and efficient solution, when compared to the alternative of investing in patchwork solutions which inadequately correct deficiencies of a functionally and physically obsolete plant.

The assessment of existing deficiencies at each VA Medical Center (VAMC) is accomplished through a combination of objective and subjective evaluations of various "Primary" and "Secondary factors". "Primary Factors" include those considerations determined to be the most important in terms of the delivery of quality medical care within the VA health care system. These factors include patient safety considerations, demonstrated need based on demographic analyses of current and projected inpatient workloads and outpatient visits and the analysis of existing space and functional deficiencies. "Secondary Factors" encompass the age and condition of the building(s) shell and site utilities and the condition of non-patient support functions (eg. laundry, boiler plant, warehouse, etc.). In evaluating a Medical Center, greater weight is given to deficiencies in the "Primary Factors" as these impact directly on patient care. In this regard, the need to correct physical deficiencies ("Secondary Factors") is not a sufficient reason for a hospital to be placed on the "List of Ten". The hospital must have programs which are essential to the delivery of medical care in the Medical District, and it must be appropriately sited to meet the demands of the veteran population. Nevertheless, with the exception of Gainesville VAMC, where the identified deficiencies relate primarily to program requirements, all of the Medical Centers on the current "List of Ten" have obsolete physical plants.

The evaluation of a Medical Center against these primary and secondary factors, along with the analysis of input from VA program officials and Regional and Medical District Directors, Joint Commission on Accreditation of Hospitals (JCAH) teams, Systematic External Review Program (SERP) teams and architects and engineers, results in its identification as one of the VA facilities most in need of construction, replacement or major modernization. It should be noted that this decision-making process entails both quantitative and qualitative factors. For instance, fire and safety deficiencies at Medical Centers can be ranked and quantified in terms of deviations from the Life Safety Code of the National Fire Protection Association (NFPA). On the other end of the spectrum, qualitative judgments also play a significant role in assessing and ranking facility deficiencies and construction needs in terms of Agency goals and objectives, Presidential and Congressional guidance, competing program needs and overall resource constraints.

A more thorough discussion of this evaluation process is presented in the "white paper" (entitled "Development of the List of Ten") provided to Mr. Berger at the October 18th briefing. A copy of this paper is enclosed, for your convenience.

As discussed in the above mentioned "white paper", the VA recognizes shortcomings in its present evaluation and selection process. The VA also recognizes that any efforts to more effectively determine and rank our construction needs on a systemwide basis and to remove as much subjectivity as possible in the priority setting process must be based upon the collection of reliable, objective data concerning our Medical Centers and their health care delivery needs. The construction planning and priority setting process, thus far, has been an evolutionary process in that the implementation of new initiatives has provided for continual, but incremental refinement of our construction plans. These refinements are reflected in the annual Five-Year Medical Facility Construction Plan provided to Congress for review and oversight. This plan is revised and updated annually to reflect changes in construction priorities resulting from information generated by the Advance Planning Fund (APF) process, improvements in the Agency's program planning and evaluation techniques, changing medical program needs, and budget and policy guidance received from Congress and the Office of Management and Budget. The health care facility planning improvements now being implemented are far more comprehensive than past efforts and will center around the collection of objective data concerning the missions and program needs of the VAMCs, arraying this data in an overall data base and, by use of more objective analytical techniques, identifying construction needs in relation to this data. These initiatives range from a systemwide collection of data on VAMC missions and program needs through the Medical District Initiated Program Planning (MEDIPP) process to specific improvements in our data collection, workload projection and needs assessment techniques. As these refinements are implemented, the programmatic changes will be reflected in our future Five-Year Medical Facility Construction Plans. Brief descriptions of our planned initiatives in this area are as follows:

- Executive Direction and Guidance for VA Health Care Delivery

The last comprehensive review of policy options to meet veteran health care needs was accomplished in 1977-1978. I have asked the Chief Medical Director to update this comprehensive guidance. It is anticipated that this review will be completed in March or April of 1983 and will reflect the new health care facility data being generated by the MEDIPP process described below. Based on these results, I hope the new Administrator will have sufficient information and recommendations available upon which to issue updated policy guidance to provide direction to our long-range health care facility planning effort and to better determine and justify our construction priorities for FY 1985 and the years to come. To facilitate this effort and to assist current facility construction planning and the MEDIPP process, the Chief Medical Director and/or I have issued general guidance which includes the following:

1. The mission of the Department of Medicine and Surgery (DM&S) is to develop, maintain, and operate a comprehensive, nationwide and independent health care delivery system to provide eligible veterans reasonable access to the highest quality health care within resource limits as well as educate and train health personnel and conduct a program of medical research.

2. Planning for facilities and services will be based upon patient need and demand as documented by demographic and utilization data.

3. Delivery of services will be provided in the most cost-effective manner consistent with high quality care.

4. Sharing with other health care providers will be maximized.

5. After statutory requirements are met, priority attention will be accorded to planning for the aging veteran population, rehabilitation, and ambulatory care. DM&S will undertake a study of the impact of the outpatient care program on the need for inpatient care and also conduct a study on the impact of the aging veteran population on the VA medical care system. In addition, the Chief Medical Director (CMD) is conducting a complete assessment of the VA's Domiciliary and Nursing Home Care programs and developing recommendations for the future. To meet the need for Nursing Home Care, I have asked the CMD to consider a broad range of approaches including construction of new facilities and conversion of existing underutilized Medical Centers or sections thereof.

6. Through MEDIPP, the VA Medical Centers will analyze current demographic information, define the current health care status of veterans in each primary service area and the demands being placed on each Medical Center for services, conduct a capability inventory, and assess the current private sector health care delivery systems in their areas. Through MEDIPP, DM&S will also assess current VA medical facility missions and recommend adjustments which will better serve veteran health care needs.

7. The Department of Medicine and Surgery (DM&S) will develop a methodology for its manpower and staffing system based on acuity of patients' needs that can determine staff size and capability. DM&S will also establish a firm plan and schedule for implementing an improved hospital productivity measurement system.

8. The VA will continue to emphasize correction of code deficiencies (life safety, patient privacy, electrical, etc.) in its construction program. The Office of Construction will undertake a uniform evaluation of the current status and future needs of the VA's capital (physical) plant in order to provide the data bases for a systemwide assessment of current and future physical plant needs.

9. The VA will continue to expand its Spinal Cord Injury (SCI) Units with emphasis on establishing and maintaining the independence and self-sufficiency of the veteran patient to the maximum extent possible. DM&S has been directed to develop a specific methodology to determine VA SCI bed needs and appropriate SCI Unit locations.

• Strategic Management Process (SMP)

The comprehensive framework for the VA's improvements in health care facility planning is the current development by the Department of Medicine and Surgery (DM&S) of a Strategic Management Process (SMP) metholodogy. This methodology proposes to integrate three major planning initiatives undertaken by DM&S:

(1) Medical District Initiated Program Planning (MEDIPP) which identifies medical facility needs and data in support of those needs;

(2) Development of Staffing and Productivity Standards which will provide tested staffing methodologies for all medical services in order to better match resources with patient care demands based on objective productivity measures; and

(3) Development of a Resource Allocation Methodology which integrates long-range facility needs assessments, staffing needs and distributions, and cost into a single stragegic management plan.

The goal of the Strategic Management Process is to develop a comprehensive planning system which is responsive to the dynamic nature of health care planning and yet links all the planning elements together into an integrated whole. This process was developed as a specific response to top management concerns that the VA's previous health care planning effort was fragmented and uncoordinated, lacking sufficient direction and necessary operational and budgetary linkages.

- MEDICAL DISTRICT INITIATED PROGRAM PLANNING (MEDIPP)

In terms of health care construction planning, perhaps the most critical component of the Strategic Management Process is MEDIPP, a major, new planning initiative which will establish program plans on a Medical District specific basis. While MEDIPP is still in its infancy and may require several years of refinement, this decentralized (grassroots) planning process nevertheless holds great promise for the VA's long-range health care planning. The emphasis of MEDIPP is to provide central office planners with an assessment of veteran health care needs which are based on reliable demographic analyses and responsive to local conditions and variances. The assessments generated by the Medical Districts are then consolidated and analyzed by the VA's Health System Planning Service; provided to program officials for a panel review; and then presented to DM&S's Planning Review Board for resolution of the various recommendations of earlier reviews.

After receiving the first initial data submissions from each Medical District last January, the Department of Medicine and Surgery has just received the first full MEDIPP submissions this month from each of the 28 Medical Districts. Policy formulation based on these 28 submissions will be forthcoming in the Spring of 1983. In the meantime, the MEDIPP process calls for an annual update that will provide for an ongoing review of our health care efforts and help us to continuously refine our planning data. After the 1982 MEDIPP submissions are analyzed, the Medical Districts will begin work on the development of their 1983 submissions.

- Improvements in VA Planning Data

Critical to any planning system is assurance that the data upon which decisions and plans are being formulated are accurate and reliable. This has been a particular concern of mine while I have served at the VA. To ensure that the data available to VA health care planners keeps pace with the procedural improvements undertaken, a broad variety of initiatives have been undertaken to refine and improve data collection and the Agency's data bases. These initiatives are as follows:

1. Physical Plant Evaluation - The VA's attempts to conduct an effective assessment of facility construction needs systemwide have been hampered in the past by the lack of a comprehensive data base which can be used to compare and rank relative needs among all the VAMCs. To address this problem in terms of the VA's physical plant, I strongly support an Office of Construction proposal to conduct physical plant evaluations at the 120 VA medical facilities built before 1970 for which systems deficiency information is most lacking. In this regard, a methodology recently has been developed and successfully tested that will provide the basis for a uniform technical assessment of all of the VA medical facilities. This survey provides more reliable data upon which to assess the current condition of our physical plants and will provide an analysis of what will be necessary to bring the plant "up to shape", including an estimate of the total costs involved. The survey proposes to analyze existing facilities by specific buildings in terms of established standards in the areas of fire and safety, seismic, architectural and building construction, equipment, structural limitations, heating, ventilation and air conditioning, plumbing and sanitary facilities, asbestos, electrical, boiler plant, outdoor utilities, and automatic transport systems, and standards put forth by the Joint Commission on Accreditation of Hospitals (JCAH). Subject to the availability of funds, the survey itself will be undertaken in FY 1984 and will take approximately 1 to 1-1/2 years to complete. I believe this proposal will provide a significantly improved planning base for prioritizing and justifying future construction decisions which pertain to the retention, replacement or modification of existing VA physical plants.

2. Improving the Assessment of Veteran Need/Demand - The effort to improve the methodology to help guide the assessment of veteran need/demand for VA health care programs is a continuous process that provides for internal updating of future projections of need. The veteran population component of the 1980 Census by county has not yet been fully completed by the Census Bureau, but it should be available sometime in the Spring of 1983. This data will provide the base for the VA to refine its projections on future veteran demand/ need. The Department of Medicine and Surgery has developed a draft "General Methodology Manual for Needs Assessment Studies" which will serve to provide general concepts and procedures used by Medical Districts in assessing veteran need/demand for VA health care programs as part of the MEDIPP process.

3. Refining Methodology for Making Future Workload Projections - The attempt to project future bed needs and the concomittant workload relies on bed sizing models. At the present time there is a study being conducted by University of Florida researchers (in conjunction with the VAMC at Gainesville, FL) which is formulating improvements to the existing VA/GAO Bed Sizing Model. Methodologies have already been formulated for projecting needs for VA nursing home care and domiciliary beds and these methodologies will be expanded to encompass the Spinal Cord Injury (SCI) and Renal Dialysis programs during FY 1983.

4. Front-End Planning - By placing emphasis on long-range comprehensive facility planning, our ability to react to the changing health care needs of our Medical Centers will be enhanced. The vehicle for this effort will be the individual Five-Year Facility Plans. Specific initiatives include development of facility plans based on MEDIPP program decisions, identification of firm facility improvement strategies earlier in the planning process, and increased emphasis on better project justification from the field stations.

5. Project Development - Improvements to our project development system are continuously being proposed and, where feasible, are being integrated into the system on an ongoing basis. One proposal under consideration is to extend the Advance Planning Fund (APF) process through the working drawing stage, rather than just through the preliminary drawing stage, as it is now. This would lend more continuity to the project development phase. This change would require Congressional approval for implementation.

6. Space Planning Criteria - A renewed emphasis is being placed on the development and application of VA space planning criteria to assure that we are providing cost/effective, appropriate standards for construction projects. In addition to improving the internal procedures by which space planning criteria are developed, specific studies underway include development of an intensive care planning model and an improved methodology for determining facility requirements for surgery.

7. Space and Functional Deficiency Identification (SFDI) - During FY 1983 we will be performing research analysis of the SFDI system. The thrust of this research will be an emphasis on the improvement and refinement of the system so that it can be better utilized as an evaluative tool and be fully integrated into the Five-Year Facility Planning process. Another research effort will focus on the development of a new space classification and coding methodology that can be used for analysis or research associated with program planning on a systemwide basis.

With the exception of the update to the VA guidance, the charge of all of the above initiatives, as a common central tenet, is the collection and analysis of objective data concerning the VA medical care system. The analysis of this data will serve as the basis upon which the VA can more objectively determine construction requirements and project priorities. These determinations must, understandably, be made as part of the management decision process - a process that will always retain a degree of subjectivity. I do feel, however, that with the integration of the above initiatives (and future, as of yet undetermined initiatives) into our planning process, the VA will be in a much stronger position to operate a planning process that is objectively responsive to the needs of the veterans the VA serves.

In terms of time frames for these planning improvements, we anticipate that all of the initiatives, with the exception of the physical plant evaluations, the Resource Allocation Methodology, full analytical use of the 1980 Census data, and the research analysis of the SFDI System, will be of operational use for our decision-making on the FY 1985 construction program. Obviously, many of these initiatives will require ongoing refinements and fine-tuning as the methodologies are translated to "hands-on" use and some will be more operational than others in 1983, but I believe our FY 1985 project evaluation and selection process will be greatly improved by their use. For our FY 1986 construction program, I anticipate that all of these improvements (and perhaps others not yet undertaken) will be fully implemented and integrated into a comprehensive and viable facility planning program. This is our goal, and I can assure you that it has top priority within the Agency. As you know, pending full implementation of these improvements in our health care planning process, I directed a special revalidation process as an interim measure to ensure that the construction projects we propose for FY 1984 represent a sound and fully justified construction program based on accurate and defensible planning data. We believe our FY 1984 revalidation effort, now completed, met this goal.

Before closing, I wish to emphasize that while these new initiatives are being implemented, the VA is also continuing its efforts to control construction costs. We have undertaken a number of efforts in this regard, including a research project to conduct an independent private sector review of the VA's design and construction requirements and implementation of nursing home cost reduction elements identified by the VA's Nursing Home Cost Reduction Task Force. This latter effort has achieved estimated cost savings of $1.5 million per 120 bed nursing home care unit thus far. Construction cost containment will remain a major emphasis as we undertake parallel improvements in our project selection, development and evaluation processes.

In our continuing efforts to refine and strengthen our planning process, your interest and support are greatly appreciated, and we look forward to the opportunity of working with you in our future endeavors. It is my sincere hope that the Agency's planning initiatives will provide improved assistance to you in the evaluation of our funding decisions, and we welcome your counsel in this critical process.

Sincerely,

Everett Alvarez
Deputy Administrator For

ROBERT P. NIMMO
Administrator

Enclosure

DEVELOPMENT OF THE LIST OF TEN

As VA facilities get older, they develop critical space and functional deficiencies in terms of the delivery of modern health care that require a multiple corrective approach involving either total replacement or major modernization. Changes in characteristics of the veteran population, including migratory patterns, also create the need for expansions of medical facilities to provide needed care. These VA medical facilities determined to be most in need of construction, replacement or modernization share common characteristics: to a greater or lesser extent these facilities have space, functional and technical deficiencies; operating officials and program managers assess the facilities to be inadequate to meet health care delivery needs; often substantial amounts of incremental construction have been identified to enable the facility to continue operation; and it is anticipated that a long-range comprehensive facility plan will indicate that replacement or modernization is the solution to correcting the identified deficiencies. This comprehensive approach is determined to be more efficient and cost-effective than a recurring multiple project approach.

Assessment of existing deficiencies at each VA Medical Center (VAMC) is a combination of objective and subjective evaluations of various "primary" and "secondary factors". "Primary Factors" include those considerations determined to be the most important in terms of the delivery of quality medical (patient) care within the VA health care system. These "Primary Factors" encompass patient safety (eg. fire/safety deficiencies as determined by the applicable NFPA Life Safety Code and correction of seismic deficiencies); demonstrated need based on demographic analyses of current and projected inpatient workloads and outpatient visits (as calculated by the VA/GAO Bed Sizing Model and/or the Outpatient Projection Model); space and functional deficiencies in patient and clinical areas (using Space and Functional

Deficiency Identification (SFDI) comparisons between existing space and approved Agency space planning criteria (H-08-9)); compliance with patient privacy and handicap access standards (VA and ANSI); and the medical delivery role of the Medical Center in the VA system (type of VAMC and degree of affiliation). Thus, a Medical Center which, in a relative sense, exhibits a more serious degree of fire and safety deficiencies than another gets a higher rating in that category; the Medical Center with greater space and functional deficiencies is given a higher rating, and so forth. Likewise, in considering demographics, the Medical Center that is projecting the greater increase in patient days or outpatient visits, but is saddled with the least adequate facilities to support this increase, receives a higher rating. Finally, greater emphasis is placed on the more active, highly affiliated and specialized Medical Centers because of the more sophisticated level of medical, surgical and psychiatric care provided.

"Secondary Factors", while also important to the operational functioning of a modern health care facility, include deficiencies which impact indirectly on patient care. "Secondary Factors" encompass the age and condition of the building(s) shell and site utilities (mechanical, electrical, plumbing, A/C, etc.); energy conservation; and the condition of non-patient support functions such as laundry, boiler plant and warehouse. Within these factors, greater emphasis is given to correction of the most serious identified deficiencies.

The evaluation of a Medical Center against the above primary and secondary factors and the analysis of input from program officials, Regional and Medical District Directors results in its identification as one of the VA facilities most in need of construction, replacement or major modernization and also identifies its relative priority against the other "List of Ten"

Medical Centers. In terms of the evaluative process, more emphasis is given to the "Primary Factors" as these impact directly on patient care. The prioritization of these Medical Centers is extremely difficult in that all the facilities are measurably deficient and the effect on the provisions of patient care is significant. As stated previously, the rationale for prioritization is a balance of objective and subjective evaluations and it is arrived at through the Five-Year Facility Plan process.

In accordance with the provisions of Public Law 96-22, Section 5007, the VA submitted to Congress the first Five-Year Medical Facility Construction Plan in August 1979. This FY 1980-FY 1984 Plan, prepared by the VA's Department of Medicine and Surgery under the direction of its Chief Medical Director, Dr. James C. Crutcher, included a "priority listing" of those hospitals determined to be most in need of construction, replacement or major renovation, exclusive of alteration projects or replacement projects for which funds had already been appropriated by Congress (eg. the eight replacement hospitals approved by President Ford). The resulting listing of ten hospitals was as follows:

1. Minneapolis, Minnesota
2. Houston, Texas
3. New Orleans, Louisiana
4. Palo Alto (Menlo Park Division), California
5. Tuscon, Arizona
6. Allen Park, Michigan
7. Albuquerque, New Mexico
8. Mountain Home, Tennessee
9. Pittsburgh (Aspinwall Division), Pennsylvania
10. Augusta (Lenwood Division), Georgia

This listing remained unchanged until the third Five-Year Medical Facility Construction Plan for FY 1982-FY 1986, submitted in June 1981. Congressional approval of funding for projects at New Orleans, Louisiana, and Tuscon, Arizona, afforded the opportunity for the next hospitals evaluated to be most in need of construction, replacement or major modernization to be added to the List. The remaining projects on the list (eight in all) were moved up in line and, as such, comprised the first eight positions. In relation to the original "List of Ten" the Medical Centers at Biloxi, Mississippi, and Gainesville, Florida, were placed as the next in line as numbers 9 and 10.

Just before the preparation of the FY 1982-FY 1986 Plan, the planned Replacement Hospital at Baltimore, Maryland, was rescinded by OMB as part of the new Administration's ongoing review of the Federal Budget. Baltimore had been one of the original eight replacement hospitals approved by President Ford and, as such, had not been included on the original FY 1980-FY 1984 "List of Ten". As a result of the rescind directive, the VA was obligated to reevaluate approaches for construction to meet the medical needs in the greater Baltimore area.

With the approval of funding for the project at Palo Alto, California, the remaining projects again moved up in line, which created an opening in the tenth position. Corrective strategies to meet the medical care needs in the Baltimore area still exist. The VA has been intensely evaluating all options for correction of the existing deficiencies, and although no decisions have been made as to the corrective approach to take, the VA decided to place the Baltimore area project in the open tenth position on the list of ten medical centers most in need of construction, replacement or major modernization.

With the exceptions of the addition of three Medical Centers to the List and the deletion of three funded projects, the "List of Ten" and their relative priority have remained unchanged since the first Medical Facility Construction Plan was submitted. However, the relative priority with regard to need at the VAMC should not be construed as a priority order for accomplishment of any project in question. The various elements of the planning and design process, along with other unforseeable contingencies, cause each project to follow varying and often uncontrollable timeframes as they move toward a position where the VA is ready to request construction funding. Factors such as development of demographic packages and needs assessments, concepts to be chosen from, design of preliminary drawings, cost estimates and funding availability in a limited budgetary resource milieu do not follow a set course for each project. Therefore, projects such as Minneapolis and Houston, which have held the number 1 and 2 positions on the List since the FY 1980-FY 1984 Plan, have not been the first and second projects proposed for construction funding. While the Minneapolis project has already received design funding in FY 1981, the planning and design of the Houston project has completely stopped as of this date. Based on an informal signal from OMB, the VA formally applied to Congress in March 1981 for approval to reprogram $6 million in Advance Planning Fund (APF) funds for the development of preliminary construction plans for a full replacement of the VAMC in Houston. The Senate Appropriations Committee, with the concurrence of the House of Representatives, denied this request in April 1981. All development of the Houston plans stopped in February 1982 at a stage of 50% completion of the master plan and 60% completion of block drawings of concepts. No further development has been accomplished since that time.

Another example of the vagaries and changing nature of the planning and design process is the Baltimore area project. Although it has only recently been placed on the "List of Ten" it is, in actuality, a project whose design (working drawings) had already been completed and which had been funded for construction, until the 1981 rescind order. If this project was given the "go ahead" now, it could conceivably be funded before other projects currently on the "List of Ten".

Each of the remaining projects on the List are in various stages of development. A status report on these projects is included as Attachment 1.

An ongoing goal of the VA's construction planning process is to continue to refine the existing system so that it will provide a more consistent and structured basis upon which to determine the physical and programatic needs of the Medical Centers systemwide and accommodate on a dynamic basis, VAMC mission changes and changing veteran health care needs. While health care planning remains, on a large extent, to be based upon professional and medical judgments which are essential to the process of refining the VA's abilities to select projects, the VA recognizes shortcomings in the present process. In this regard, the VA is currently formulating and implementing major revisions and refinements to the planning process. These revisions and refinements, which began with the revalidation process of this past Spring, will first impact on the development of the FY 1984-FY 1988 Medical Facility Construction Plan. The major initiative now being implemented is the Medical District Initiated Program Planning (MEDIPP) process, whose goal is to establish program plans on a Medical District (grassroots) specific basis. The first MEDIPP submission is due into VA Central Office in November 1982. Other planning initiatives include the following:

- Improving the methodology to help guide the assessment of veteran need/demand for VA health care programs.
- Improving the procedures by which we develop Space Planning Criteria by improving the methodology for determining facility and systemwide requirements for surgery, SCI beds, nursing home care units, ICU's, etc.
- Continuing refinement of the Space and Functional Deficiency Identification System (SFDI).
- Refining the methodology for making future workload projections and developing staffing standard models to support increased workloads.
- Refining the APF process (perhaps through working drawings) and continuing to assess and seek improvements in the project development project.
- Emphasizing long-range comprehensive facility planning, sometimes referred to as "front-end planning".
- Developing methodology for performing physical plant evaluations of VAMCs to determine current and future needs.

These initiatives, in conjunction with the ongoing results from the MEDIPP process, will be utilized to facilitate the further improvement of the individual Medical Facility Five-Year Plans and the annual Medical Facility Construction Plan and serve as the foundation upon which the VA can more objectively determine construction requirements and project priorities. The anticipated outcome will be a planning system that is the most responsive to the needs of the veterans the VA serves.

ATTACHMENT 1

PROJECT STATUS

Allen Park	The Technical Evaluation Study of the existing medical center has been completed and the report is being reviewed in Central Office. A contract has been awarded to an A/E firm to develop concepts in conjunction with the Master Plan.
Albuquerque	The working drawings, second review, are near completion. This project is on schedule with a construction award scheduled for July 1983. Design funding was provided in FY 1982, with final construction funds included in FY 1983.
Mountain Home	The Master Plan concepts have been completed by an A/E firm with the final conceptional alternative selected on September 21, 1982. The next phase is to have preliminary plans developed for accurate cost estimates and final bid preparations.
Pittsburgh	An A/E firm has been contracted to develop conceptional designs for either renovation and/or replacement of this medical center. The A/E contract has been placed on hold pending development of new workload projections.
Augusta	An A/E firm has recently completed the Master Plan which provides three conceptional alternatives. These alternative concepts are presently being reviewed in Central Office.
Biloxi	Design funds for this medical center have been provided in the FY 1983 Budget. The project submission is in the final stage of approval and working drawings are scheduled to be completed in June 1983.
Gainesville	Development of this project is being held pending receipt of the Medical District MEDIPP submission which will provide the basis for future constrution in the State of Florida.

RELATIVE DEGREE OF DEFICIENCY - PRIMARY AND SECONDARY FACTORS

Medical Center Level of Care	Minneapolis Tertiary	Houston Tertiary	Allen Park Tertiary	Albuquerque Tertiary	Mountain Home Tertiary	(Aspinwall) Psychiatric	(Lenwood) Psychiatric	Biloxi Ter/Psy	Gainesville Tertiary	Baltimore Tertiary
PRIMARY FACTORS										
Patient Safety	Serious	Serious	Serious	Moderate	Serious	Moderate	Serious	Serious	N/A	Moderate
Projected Need Based on Demographics	Moderate	Moderate	Moderate	Minimal	Moderate	Minimal	Minimal	Minimal	Serious*	Serious
Existing Space and Functional Deficiencies in: • Patient Areas	Moderate	Moderate	Serious	Moderate	Serious	Serious	Serious	Serious	N/A	Serious
• Clinical Areas	Serious	Minimal	Moderate	Moderate	Minimal	Minimal	Minimal	Minimal	N/A	Moderate
SECONDARY FACTORS										
Technical Deficiencies in: • Building Shell	Serious	Serious	Minimal	Serious	Serious	Serious	Serious	Serious	N/A	Minimal
• Major Systems	Moderate	Serious	Moderate	Serious	Moderate	Moderate	Moderate	Minimal	N/A	Moderate
• Energy Conservation	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Minimal	Moderate	N/A	Moderate
Non-Clinical Support Deficiencies in: • Warehouse	Moderate	Minimal	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Laundry	Moderate	Moderate	N/A	N/A	N/A	N/A	N/A	Moderate	N/A	N/A
• Boiler Plant	Moderate	Moderate	Moderate	Moderate	N/A	N/A	N/A	Serious	N/A	N/A

* The Gainesville project represents the addition of a new Psychiatric Facility to meet the overwhelming demand for psychiatric beds in the State of Florida. Therefore, all the other primary and secondary factors were not considered when evaluating the relative priority of this project.

ID No. 1

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Alexandria, LA	3	502-058	Clin. Improvements & Relocate Support Function	6/82	30,000

American Legion Field Report No. 0-002

Visitation Dates: January 14-18, 1980

OBSERVATIONS

Space & Construction Needs: Currently a major physical plan deficiency exists with the medical building and the admissions & outpatient care facilities, occupying two separate areas. Consolidation of these two functions is included in the Five Year Facility Plan. Until this project is completed many admissions will be aggravated by transportation of patients from the admissions area across the Medical Center grounds to the medical building. Included in this Medical Facility Improvement Plan (completion scheduled for 1985) will be new operating rooms for surgery, special procedures room for surgery and a new ambulance entrance with emergency room.

RECOMMENDATION

1. In order to consolidate all medical functions, it is recommended to the Administrator of Veterans Affairs and the Chief Medical Director that the Medical Facility Improvement Plan, as outlined in the Five Year Facility Plan, be expedited.

Chief Medical Director's response to Recommendation No. 1:
April 18, 1980

A $12 million clinical improvement project has received advance planning funds and an overall plan has been developed which will accomplish the consolidation of medical functions. This plan is being considered for design and construction in an early budget year.

ID No. 1
April 14, 1982

VAMC Director Comment: Walter Armstrong, Jr. indicated that this(~~these~~) project is necessary because:

The majority of the buildings that will be affected are of the 1929 vintage. This hospital has 120 acres and 20 buildings. Patients are occupying 3 separate buildings. The 30 million dollar price tag is a "no frills" type project. To do it right, 64 million dollars would be needed. Numerous fire and safety deficiencies and patient privacy shortcomings will be corrected with this project. The last JCAH survey resulted in only a 1 year accreditation because of fire and safety problems. A resurvey visitation in December 1981 was conducted. The results of this survey have not been received todate. The Director stated that the conditions still exist but will probably satisfy JCAH because of projects pending. Personnel from VACO will be at this facility approximately April 26, 1982 to consider the revalidation of this project and ascertain what modifications can be made to reduce costs. If this project is not approved, the Director stated that this facility will definitely have to have a new surgical intensive care unit, modern bathrooms, and a great deal of other work will have to be accomplished in the near future.

Department Adjutant Comment: Mr. James E. Tripp

Nothing to add to the Director's comments.

Department Service Officer Comment:

Not available.

ID No. 2

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Amarillo, TX	6	504-026	Addn/Renov. Clinical Support	6/81	44,000

American Legion Field Report No. 8-051 / 1-036

Visitation Dates: August 14-17, 1978 and August 17-21, 1981

Space & Construction Needs: Space deficiencies and the need for additional clinics and bed space have been identified at least during the past two visitations. In '81 during the entire visit it was noted that "space is most acute." Because of the large primary service area the work load at the facility continues to grow. The Ambulatory Care area is crowded with the only relief in sight being the new Clinical Building. Space needs are cited for Surgery, Rehabilitation Medicine Service and Pharmacy.

1. August '78 - A most pressing need was identified as additional clinical space and bed space as submitted in the Facility's Five Year Plan.

2. August '81 - Recommendation No. 1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director lend their support to the planned construction not delay the proposed schedule, which also includes Nursing Care Beds.

Chief Medical Director's response to Recommendation No.

Response September '78 ... There are two major construction projects in the Advance Planning Fund which was designed to correct clinical deficiencies and patient privacy problems .....

Response December '81: Recommendation No. 1. The Nursing Home Care Unit project is included in the VAMC Amarillo Five Year Plan. The final decision will be based on several factors, such as bed need projections for Medical District 25 and the availability of resources.

ID No. 2
April 20, 1982

VAMC Director Comment: Mr. Grogan 4/14/82 **indicated that this(these) project is necessary because:**

This VAMC serves veterans residing in a 5 State area. The patient case load has been ever increasing with Ambulatory Care being budgeted for 20,000 visits yet expecting 30,000 visits this year. The Director related that the need for this project is paramount. If it is not approved the VAMC will default its JCAH Accreditation. Not only have there been numerous JCAH citations, but the District safety officer has also cited fire and safety precaution needs. The Director related that Surgery is on the 4th floor while the recovery room is on the 2nd floor. Patients are transported from one area to the other via an elevator that sporadically works. The other day the service elevator was out of order, and patients had to be transferred via the public elevator used by visitors. JCAH has cited ICU for not having patient privacy because there are eight beds in one room lined against a wall. X-ray has been cited for being at the end of a corridor with no way out. Dentistry has space deficiencies and is cramped. Lab has no 2nd exit, leaving the prospect of these people having difficulty getting out of there. Yesterday, the Director met with Dr. David West who is the Executive Director for Planning and Construction regarding revalidating this project. No statement was given regarding the status of this project.

Department Adjutant Comment: Mr. W. H. McGregor 4/14/82

When contacted made a referral to County Service Officer Ray Cliver who he felt was most knowledgeable about the situation.

Department Service Officer Comment:

Ray Cliver was not available for comment.

ID No. 3

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
2	Bath, NY	1	514-068	Renovate Bldg. 78 for NHCU	12/80	7,200

American Legion Field Report No. 0-021

Visitation Dates: July 14-18, 1980

Space & Construction Needs:

CONCLUSIONS

3. Another need discussed was the proposed consolidation project for the two NHCUs (Hospital & Domiciliary). The project as outlined in the Five Year Facility Plan calls for a new building for FY '82 with 124 operating beds. The consolidation will mean a total bed loss of 56 operating beds. What will be most beneficial, however, is the freeing up of space that will be accomplished when the two NHCUs are vacated. The Medical Center has definitive ideas for these areas when the time comes.

Chief Medical Director's response to Conclusion No. 3.

November 4, 1980

The feasibility of a new construction project to consolidate the Hospital and Domiciliary NHCU vis-a-vis the renovation of these units is under review.

ID No. 3

April 19, 1982

VAMC Director Comment: Mr. Milton Salmon **indicated that this(these) project is necessary because:**

The current NHCU set-up is just not adequate. It does not meet JCAH requirements for space, patient privacy, and is lacking a nursing call system. The waiting list has increased from 40 in July 1980 to 54 on April 13, 1982.

The JCAH gave only a one year Accreditation to this facility. They are due back within a couple of months.

Department Adjutant Comment: Mr. Leonard E. Baxter

This Medical Center is an old facility and needs many renovations. A NHCU is needed for New York State veterans.

Department Service Officer Comment: Mr. Douglas Wheat

Up-to-date NHCUs are needed in New York State. This project is needed to better care for the New York State aging veterans.

ID No. 4

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Battle Creek, MI	4	515-083	Renovate Bldg. 82 (First and Second Floors-Patient Privacy)	2/82	5,800

American Legion Field Report No.

Visitation Dates:

Space & Construction Needs:

No reference was made to this project in the Field Reports.

Chief Medical Director's response to Recommendation No.

The Chief Medical Director did not respond to the need for this project in his letter.

HP No. 4
April 19, 1982

Assistant
VAMC Director Comment: F. Ward Miller indicated that this(these) project is necessary because:

This project deals primarily with fire and safety deficiencies as well as patient privacy shortcomings. JCAH (February 81) cited these deficiencies. The Assistant Director feels confident that this project will be approved after the revalidation procedure. All indications from VACO imply that this renovation will proceed on schedule.

Department Adjutant Comment: Mr. F. Gerritt Veldman

Referred me to Department Service Officer.

Department Service Officer Comment: Mr. Leo Leggett

Latest word received was that this project would be on schedule. It is sorely needed to ensure patient safety.

ID No. 5

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Beckley, WVA	2	517-013	Clinical Additions & Alterations	10/80	25,000

American Legion Field Report No. 0-007

Visitation Dates: March 10-14, 1980

Space & Construction Needs:

A Clinical Addition to expand and improve the Ambulatory Health Care Service and cope with space deficiencies that exist in all areas. There is a major construction project for Clinical Additions and Alterations scheduled for Fiscal Year 1982 in the hospital's 5-year plan. This $11,500,000 project consists of 2 two story additions to Building 1. These additions will eliminate space deficiencies in: Ambulatory Care, Canteen, Laboratory, Pharmacy, Radiology, Supply Processing and Distribution and Warehouse. Space for a Mental Hygiene Service would also become available.

Chief Medical Director's response to Recommendation No.

1. I regret that due to systemwide priorities, available resources and budget lead-time, the project for a Clinical Addition at Beckley cannot be rescheduled to Fiscal Year 1981. Every effort will be made to expedite the current project to the extent possible.

ID No. 5
April 14, 1982

VAMC Director Comment: indicated that this(these) project is necessary because:

With the present buildings no space requirements can be met. Changes must be made to alter entrance into Laboratory, Radiology and the Dental Service. The increasing work load cannot be timely processed and waiting periods are lengthy.

Studies have been made by Central Office and the needs have been documented. A JCAH review is due in the near future and it is expected that criticism will be received in many of these areas.

Department Adjutant Comment: Mr. Robert E. Vass, Sr.

Mr. Vass, Department Adjutant, fully supports the upgrading of the Clinical Building and the alterations which are now planned.

Department Service Officer Comment: Mr. Roland Savilla

Mr. Savilla, Department Service Officer, makes periodic visits to the Medical Center and wholeheartedly supports the proposed Clinical Addition.

ID No. 6

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Biloxi, MS	3	520-056	Modernize Various Buildings (BD & GD)	9/82	87,300

American Legion Field Report No. 9-061

Visitation Dates: November 26-30, 1979

Space & Construction Needs:

Currently, there are 8 major or minor recurring projects ongoing, at a cost of approximately 38 million dollars. There are 17 non-recurring projects costing approximately 10 million dollars. Included in these are clinical addition to Building 1, renovation of Building 2 and modernization of Buildings 1-3-4-5-9-41-43 and 57. The above mentioned are perhaps the most essential.

Chief Medical Director's response to Recommendation No. 1.

"Although we agree with the desirability of completing the major facility improvements project at this Medical Center, we must consider the funding of construction projects in accordance with systemwide priorities and the availability of resources. As resources become available, we will consider the construction needs of Biloxi Medical Center."

ID NO. 9
April 16, 1982

VAMC Director Comment: James H. Caldwell, Jr. **indicated that this(these) project is necessary because:**

Safety and patient privacy deficiencies exist throughout. There is little doubt that JCAH will identify many of these shortcomings. Numerous special visits from VACO (and SERP visits) have long identified these problems. The Director is optimistic that this project will be awarded.

Department Adjutant Comment: Mr. Martin O. Blanchard, Jr.

No Comment.

Department Service Officer Comment: Mr. James H. Powell

This need has been discussed, checked, and double checked over the years. Small projects have managed to keep things together, but major work must be done to alleviate patient privacy problems and improve safety for patients and employees.

ID No. 7

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
1	Brockton, MA	1	525-016a	Modernize Bldgs. 2 & 7	8-79	29, 500

American Legion Field Report No. 0-040

Visitation Dates: November 3-7, 1980

Space & Construction Needs:

OBSERVATIONS: The Director stated that he anticipates to lose approximately 100 operating beds to privacy renovations in Buildings 2 & 7. A Five Year Facility Plan project scheduled for FY '84 calls for privacy renovations and fire and safety corrections, as a result of JCAH deficiencies.

Chief Medical Director's response to Recommendation No.

The Chief Medical Director did not include this project in his response on January 28, 1981.

ID NO. 7
April 19, 1982

VAMC Director Comment: Mr. Mel A. Gores **indicated that this(these) project is necessary because:**

This project addresses the fire and safety deficiencies and the patient privacy shortages. JCAH cited both fire and safety and patient privacy as early as 1978.

Department Adjutant Comment: Mr. John P. Swift

Mr. Swift did not know about the project.

Department Service Officer Comment: Mr. Philip J. Gavin, Jr.

He was ill in the hospital.

ID No. 8

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
1	Brockton, MA	1	525-021	Addition & Renovation for SCI	6/82	6,800

American Legion Field Report No. 0-040

Visitation Dates: November 3-7, 1980

Space & Construction Needs:

SPINAL CORD INJURY (SCIU): SCIU management and patients alike are dissatisfied with space allocations within the bedrooms. The problem exists with insufficient square footage allocated to each bed. These deficiencies should be corrected by an approved 20 bed addition to Building 8. The construction project is listed in the Five Year Facility Plan scheduled for FY '82.

Chief Medical Director's response to Recommendation No.

The Chief Medical Director's response did not address the need for this project.

ID No. 8

April 19, 1982

VAMC Director Comment: Mr. Mel A. Gores indicated that this(these) project is necessary because:

There are space deficiencies on the Spinal Cord Injury Unit. This project will address these problems. There are 145 acres at this facility. There is a lot of space, but it is not functional for the modern medical procedures.

Department Adjutant Comment: Mr. John P. Swift

He did not know about the project.

Department Service Officer Comment: Mr. Philip J. Gavin, Jr.

He was ill in the hospital.

ID No. 9

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
2	Buffalo, NY	1	528-039	* Research & Education Facility	3/81	27,400

American Legion Field Report No. 0-030

Visitation Dates: August 25-29, 1980

Space & Construction Needs:

COORDINATION

During the initial interview, the need for additional space was discussed. Included in the Five Year Facility Plan is the proposed construction of a Research & Education Building that will provide an additional 69,950 net square feet (NSF) - 56,660 NSF for Research; 13,290 NSF for Education. Vacated space in the main hospital will total 28,543 NSF.

PROFESSIONAL SERVICES

When questioned about the existing space in the Medical Center, the Acting COS replied, "It stinks!" Of particular concern is the lack of clinical, office, and storage space.

NEUROLOGY SERVICE, ALCOHOL TREATMENT, MEDICAL SERVICE, SURGICAL SERVICE, RMS, NHCU, NURSING SERVICE

All of the above services and areas cited space problems.

RECOMMENDATIONS

1. It is recommended to the Administrator of Veterans Affairs and to the Chief Medical Director that funds be provided for the construction of the Research & Education Building.

Chief Medical Director's response to Recommendation No. 1.

December 18, 1980

In response to the one recommendation in the Report, construction of the Research & Education Building is an approved project. Preliminary cost estimates are being developed. The new building will provide 28,800 square feet for Research and 40,000 square feet for Education.

ID No. 9
April 19, 1982 * The project is being renamed Research Bldg/Clinical Expansion

Assistant
VAMC Director Comment: Mr. Edward Seiler indicated that this(these) project is necessary because:

Research needs to be consolidated rather than scattered around the facility. Urology, Psychiatry, Neurology, some of MAS, and a number of medical service specialties and support services need more space. Ambulatory Care needs additional space for Urology, Orthopedics, minor surgery and General Medical Clinics. A vacated R&E area would be used to start an Alcohol Treatment Center. JCAH has made comments regarding having animal research in the hospital building.

The original structure was to be four stodies. The IG visited and eliminated one floor of the building. Some conference rooms, Education and Research space were lost. The Assistant Director said they have accepted the revised plans and are now trying to keep the scaled down project on schedule.

Department Adjutant Comment: Mr. Leonard E. Baxter

Said he's not familiar with the project, but suggested I call Mr. Walter Kownaski. Mr. Kownaski said he could not see any reason to hold up the project. He said he is against any cuts in the VA that would lessen veteran benefits or medical care.

Department Service Officer Comment: Mr. Douglas Wheat

He was not familiar with this project, but after hearing about it he wondered if it had something to do with the attempts to close surgery at Batavia, NY VAMC, and have the veterans go to Buffalo and/or Syracuse for surgery.

ID No. 10

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
3	Castle Point, NY	1	533-056	Building Addition	5/81	15,000

American Legion Field Report No. 1-055

Visitation Dates: November 2-6, 1981

Space & Construction Needs:

COORDINATION

According to the Asst. Director, this Medical Center's lack of space has been cited by the JCAH. CONCLUSIONS: SERP also cited the space shortages. MEDICAL ADMINISTRATIVE SERVICE: This service is very cramped and congested and is located in a building which is remote from patient care areas. MEDICAL SERVICE: A severe lack of storage and office space on the wards was noted. SPINAL CORD INJURY UNIT: Space is very cramped. Additional storage space is needed for medical equipment and supplies. RMS: Additional storage space for medical equipment is needed. PHARMACY SERVICE was noted to be extremely cramped and congested. The implementation of the Unit Dose System would be impossible without additional space. DIETETICS & VAVS: Storage and office and storage were identified by these services, respectively.

RECOMMENDATION No. 2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director continue to support the construction of the proposed Building Addition as outlined in the 5 Year Plan. It is currently slated for design and construction in FY '84.

Chief Medical Director's response to Recommendation No. 2. Construction of the proposed Building Addition is presently planned for design and construction in FY '85, at a cost of $15,000,000.

January 26, 1982

ID No. 10
April 19, 1982

VAMC Director Comment: Dr. Henry M. Dratz indicated that this(these) project is necessary because:

Bed space needs to be brought into JCAH criteria. Processing and Distribution (PAD) needs to be brought up to JCAH standards. (Currently, the clean side is separated from the dirty side by a line on the floor). The Pharmacy needs to double its space to implement the Unit Dose Program. The Canteen needs additional space. Psychology offices are being taken over by Pharmacy Service. Patient Education offices are being taken over by the Pharmacy. There are no Chaplain offices and only four offices for nine social workers. Recreational space is located in the middle of the surgical ward. Additional elevators are needed. Currently, the passenger elevator is also used as a freight elevator.

Department Adjutant Comment: Mr. Leonard E. Baxter

Feels this project is well justified. There are many space deficiencies at this Medical Center.

Department Service Officer Comment: Mr. Douglas A. Wheat

Feels this project is needed badly. There are many space problems at this facility.

ID No. 11

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Charleston, SC	3	534-015	Clinical Addition	4/82	20,000

American Legion Field Report No. 8-061

Visitation Dates: October 16-19, 1978

Space & Construction Needs:

A clinical building addition is needed. This building would eliminate all of the clinical space shortages that exist today.

Most pressing needs:

Space in all areas (especially Laboratory and Pharmacy)

2. It is recommended that consideration be given, by Central Office, to construction of a new clinical building to eliminate all of the clinical space shortages that exist.

Chief Medical Director's response to Recommendation No. 2.

"An Advance Planning Fund project for FY 1979 is being developed to add space to the hospital for Clinical Services. This project will address those areas with the most critical need (e.g. Laboratory, Radiology, and Pharmacy)."

ID No. 11

April 16, 1982

VAMC Director Comment: J. Fred Hoefer, Jr.   **indicated that this(these) project is necessary because:**

of critical space shortages throughout the facility, especially Dental, Pharmacy and Laboratory. The Director is sure of the need and is hopeful the team that is scheduled to arrive at the end of the month will further support the justification. A March 1980 visit by JCAH confirmed the need for additional space in many services.

Department Adjutant Comment: Mr. James A. Hamilton, Sr.

Mr. Hamilton is aware of this need and supports it completely.

Department Service Officer Comment: Mr. Hoyt B. Hill, Jr.

Not available.

ID No. 12

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Cheyenne, WY	5	442-023	Exp./Renow. Building 1 (Clinical Function)	11/82	7,700

American Legion Field Report No. 6-074 and American Legion Report No. 7-067

Visitation Dates: April 5-9, 1976 and August 15-19, 1977

Space & Construction Needs:

III - Conclusions: Based on observations made and information furnished by staff, personnel, inpatient, outpatients and volunteers, it is concluded that this hospital, in spite of space deficiencies in the following services, Ambulatory Care, Laboratory, Dental, and Rehabilitation Medicine, is providing a high quality of care. It is further concluded that in order to maintain this high quality of service, consideration be given by Central Office to alleviate space deficiencies by approving the addition of a new wing.

Most Pressing Needs: Approval and construction of the new wing to the hospital which will allow relocation and remodeling of the present facility. This would greatly relieve space deficiencies in most of the hospital service areas.

IV - Recommendations: It is recommended that Central Office provide the Director, VA Center, Cheyenne, Wyoming the necessary funding to construct a new clinical wing.

Chief Medical Director's response to Recommendation No. 1. The elimination of space deficiencies and the provision of necessary expansion, including items such as a new clinical building, will be programmed to the extent resources are available and within priorities determined for the VA medical care system.

July 15, 1976

ID No. 12
April 15, 1982

VAMC Director Comment: Mr. Gravely **indicated that this(these) project is necessary because:**

The Medical Center is trying to practice 1980 medicine in a 1932 environment. The influx of veterans has placed a great burden on the facility. If this addition is not forthcoming it will greatly deter the delivery of quality health care.

Department Adjutant Comment: Mr. E. M. "Gene" Hirsch

Not available due to major heart surgery

Department Service Officer Comment: Mr. James M. Nall, Jr.

Mr. Nall stated that this program is badly needed because they (the medical staff) are trying to accomplish state of the art medical procedures in buildings that were constructed during 1932.

ID No. 13

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Chicago, IL (Westside)	4	537-024	OPC Addition (Renovate Bldgs. 11a & 11b)	1/82	40,500

American Legion Field Report No. 9-012

Visitation Dates: April 16-20, 1979

Space & Construction Needs:

The Visitation Report indicated the conversion of the old Regional Office to accommodate Outpatient Clinics and the redistribution of space within the Medical Center, the lack of parking space, the current reductions in staff and beds, the shortage of space within the Medical Center, and the affiliation relationship with the University of Illinois School of Medicine.

Chief Medical Director's response to Recommendation No.

No recommendation made pertaining to this project.

ID No. 13
April 19, 1982

Acting
VAMC Director Comment: Roy Korn indicated that this(these) project is necessary because:

The Director was on vacation, so a conversation with the Acting Director was conducted. Dr. Roy Korn stressed the importance of this project. These buildings were vacated by the Regional Office. Their condition is not suitable for patient care areas (i.e. very little electrical power, air conditioning and drainage, and water). The plan is to build a badly needed Clinical Addition to connect buildings 11a and 11b with the main hospital. The buildings themselves would be utilized for some administrative functions, thereby creating additional space in the main facility. The Acting Director is also the Chief of Staff. He stated that he is doubtful JCAH will approve the present situation pertaining to the outpatient area. When the JCAH were there in February 1981, they did not review this facility on the basis of a Ambulatory Care Clinic. They have started doing this as of late however.

Department Adjutant Comment: Mr. Vincent Sanzotta

Referred to the Department Service Officer

Department Service Officer Comment: Mr. John Cryan

Agrees that this project is badly needed. The last word Mr. Cryan received was that this project will proceed on schedule.

ID No. 14

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Cincinnati, OH	4	539-026	Upgrade Electrical Distribution	3/82	3,000

American Legion Field Report No.

Visitation Dates:

Space & Construction Needs:

This topic was not discussed during recent Field Surveys.

Chief Medical Director's response to Recommendation No.

No referral to this project was addressed in the Chief Medical Director's response to Field Survey Reports.

ID No. 14
April 19, 1982

Mr. Harold Reymolds, Chief of Engineering indicated that this(these) project is necessary because:
VAMC Director Comment:

the present electrical system was installed in 1949. This system is overloaded in the main patient occupied buildings. The wiring insulation has deteriorated to the point where it crumbles if it is touched or moved. The system has been expanded to the point that it will not safely accommodate the additional construction that is presently underway. This construction includes 2 patient elevators. Serious problems will develop if this project is postponed or discontinued. Mr. Reynolds said it might be a little exaggeration on his part, but if this project is not completed the facility may have to be shut down.

The estimated cost has risen from 3 to 6 million dollars.

Department Adjutant Comment: Mr. J. P. Hone

No knowledge of electrical upgrading.

Department Service Officer Comment: Mr. Raymond Godar

Not available for comment.

ID No. 15

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Clarksburg, WVA	2	540-008	Clinical Addition & Alterations	12/82	15,000

American Legion Field Report No. 9-024

Visitation Dates: May 22-25, 1979

Space & Construction Needs:

These needs were not referred to in last Field Representative's Report.

The contents of this questionnaire were received from the Medical Center Director on April 14, 1982. It all refers to identified project covering the Clinical Addition & Alterations.

Chief Medical Director's response to Recommendation No.

No response was made to recommendation on Clinical Alterations as same was not mentioned in Field Report dated May 22-25, 1979.

ID No. 15
April 14, 1982

VAMC Director Comment: Mr. Kilcoyne **indicated that this(these) project is necessary because:**

Space is not available for patients waiting care. Chairs must be placed in hallways near Admission-Laboratory & Dental service which is against safety regulations. During regular business hours as many as 200 people go through the area. The Outpatient visits for FY 82 will total 30,780 and this is expected to increase to 44,500 by FY 84. Acute space shortage occurs in Pharmacy-Laboratory-Rehabilitation Medicine - Ambulatory Health Care - Dialysis Center and storage space. Estimates indicate an overall space shortage of nearly 25,000 square feet.

Department Adjutant Comment: Mr. Robert E. Vass, Sr.

Mr. Vass is fully supportive of this project and attends regularly scheduled meetings at the Medical Center, where these projects are discussed.

Department Service Officer Comment: Mr. Roland Savilla

Mr. Savilla also attends regularly scheduled meetings at the Medical Center and is aware of the needs. He, too, is fully supportive of the Clinical Addition.

ID No. 16

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Cleveland, OH	4	541-021	Clinical Improvement (Surgical SVC Relocation)	4/82	15,000

American Legion Field Report No. 0-039

Visitation Dates: October 20-30, 1980

Space & Construction Needs: Space problems were identified in the Pharmacy at both Divisions. In general, additional space is needed at the Wade Park Division.

CONCLUSIONS: The space expansion plans are included in the Five Year Plan.

Recommendation No. 2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director fully support and fund a project to construct additional clinical and parking facilities, as outlined in the Medical Center's Five Year Plan.

Chief Medical Director's response to Recommendation Nos. 2 and 3. The construction of additional clinical and parking facilities and the installation of an adequate telephone system, proposed in Recommendations Nos. 2 and 3, are included in our future planning for our Cleveland Medical Center. These projects will receive due consideration as funds become available within the priorities determined for our total medical care system.

February 2, 1981

ID No. 16
April 19, 1982

VAMC Director Comment: Richard Droske **indicated that this(these) project is necessary because:**

there is a critical need for additional space. Additionally, the need to move the surgical suite from the basement and put it in closer proximity to the surgical floor will be addressed. This will in turn provide badly needed space in the basement to allow for expansion of the Laboratory (cited by JCAH) and Radiology Service. No parking facilities are included at this time. The Director further stated that if this project means less than 7 operating rooms will result, the best course of action would be to let the project slide back. Ten ORs are presently available, and a minimum of 7 are needed after the relocation.

Department Adjutant Comment: Mr. J. P. Hone

No comment

Department Service Officer Comment: Mr. Robert Gainer

Personally feels that this project should be investigated. Agrees with the need, but feels 15 million dollars could be utilized in a better manner. Doesn't feel project is feasible because of the present configuration of the physical plant, among other reasons. Feels it would disrupt treatment of patients in wards currently under operation.

ID No. 17

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Durham, NC	2	558-025	Additional Elevators	12/81	4,300

American Legion Field Report No. 9-035

Visitation Dates: July 9-12, 1979

Space & Construction Needs:

As the demand for beds increases, Medical Records storage has become an acute problem. A file room of 1000 linear feet feet is needed to adequately provide storage.

No mention was made about additional elevators, even though a request has been into Central Office for 5 years.

Chief Medical Director's response to Recommendation No.

No comments were made regarding a need for more elevators. Subjects discussed pertained to updating present heating and ventilation, and air conditioning.

ID No. 17
April 16, 1982

Assistant
VAMC Director Comment: Mr. Phil Elkins indicated that this(these) project is necessary because:

A standing request has been in Central Office for 5 years for additional elevators. Personnel from Construction Service in Central Office have made evaluation studies for such needs and have found justification to approve the project. It is the opinion of management at the VAMC that this project will be approved for construction in FY 1984.

Department Adjutant [illegible] Sink

Talked with Mr. S[illegible] [illegible]il 15, 1982. He is familiar with the need for additional elevat[illegible] at the Medical Center, Durham, NC. Mr. Sink has discussed these ne[illegible] with Mr. B.F. Brown, Medical Center Director and is fully supportive of more elevators being installed.

Department Service Officer Comment: Mr. Paul L. Blake

Mr. Blake is on vacation and will not return to his office until April 20, 1982.

ID No. 18

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
East Orange, NJ	4	561-034	Reloc./Consol. Res.	10/82	5,300

American Legion Field Report No. 0-047

Visitation Dates: Dec. 1-5, 1980

Space & Construction Needs:

The Outpatient Clinic located in downtown Newark, is leased from G.S.A. Numerous attempts have been made by the Medical Center to have G.S.A. correct the deficiencies. The situation at the Outpatient Clinic can no longer be tolerated.

Recommendation No. 1. It is recommended to the Administrator of Veterans Affairs and the Chief Medical Director that every effort be made to have the intolerable conditions that exist at the Outpatient Clinic corrected.

Chief Medical Director's response to Recommendation No. 1. Since 1974, the Medical Center and VA Central Office have initiated measures to improve fire and safety deficiencies in the VA Outpatient Clinic at 20 Washington St., Newark, NJ. We were pleased to be notified by a G.S.A. Representative in January 1981 that funding has been approved for a modernization project. The project is already in its first phase which will include the addition of emergency stairwells; installation of an emergency generator; replacement of the heating system, drinking fountains, and existing elevators; and, complete modernization of the lobby and bathrooms. We are optimistic that work will soon begin on Phase II of the project which entails installation of new floors and ceiling and complete repainting of the building interior.

ID No. 18
April 15, 1982

VAMC Director Comment: Mr. Peter Baglio **indicated that this(these) project is necessary because:**

The Outpatient Clinic must be relocated since G.S.A. will not keep the present building in a satisfactory condition that is conducive to the delivery of good health care. The building is not safe to place people in and fire control is not good. A new building has been selected and a recommendation submitted to Central Office to consider leasing it.

Department Adjutant Comment: Mr. Robert W. Field

The Adjutant is on vacation and will return to his office on April 19, 1982

Department Service Officer Comment: Mr. Thaddeus J. Gnidziejko

Mr. Gnidziejko is supportive of a new location of the Outpatient Clinic, preferably at the Medical Center. He supports selection of another building, provided public transportation is available so that veterans can reach it with no delay.

ID No. 19

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
East Orange, NJ	4	561-035	120 bed N.H.C.U.	2-85	15,000

American Legion Field Report No. 0-047

Visitation Dates: Dec. 1-5, 1980

Space & Construction Needs: Space problems appear in many areas of the Medical Center. The construction of a new 120 bed Nursing Home Care Unit is essential in order to meet the demands for such care. During this visit the waiting list for the N.H.C. was 31.

Recommendation No. 3. It is recommended to the Administrator of Veterans Affairs and the Chief Medical Director that the funding for the 120 bed N.H.C.U. be outlined in the Five Year Facility Plan and be expedited.

Chief Medical Director's response to Recommendation No.

Recommendation No. 3. Funding for a 120 bed Nursing Home Care Unit has been proposed for inclusion in long-range plans for the Medical Center in conjunction with the total VA Nursing Home bed plan.

ID No. 19
April 15, 1982

VAMC Director Comment: Mr. Peter Baglio **indicated that this(these) project is necessary because:**

Due to the demand for Nursing Home Care beds it is essential that a 120 bed N.H.C.U. be constructed. It is impossible to accept any more applications at this time since beds are not available. Space is not available for a swing unit so that the present N.H.C.U. can be modernized.

Department Adjutant Comment: Mr. Robert Field

The Adjutant is on vacation and will return to the office on April 19, 1982.

Department Service Officer Comment: Mr. Thaddeus J. Gnidziejko

A long needed plan for more N.H.C. beds has existed for 4 years. Currently, more veterans are seeking this type care and space or beds are not available for such care.

ID No. 20

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Fayetteville, NC	2	565-027	Clinical Addition	4/82	15,800

American Legion Field Report No. 9-039

Visitation Dates: July 16-19, 1979

Space & Construction Needs:

Planned construction of the expansion of the Outpatient Clinic and the alleviation of some storage deficiencies by utilizing a building as a supply warehouse.

Visitation Report of December 1979 mentions plans for a new wing in the planning for Fiscal Year 1979, with the design stage during Fiscal Year 1980 and construction in Fiscal Year 1981.

Most pressing need shown in 1976 was more space in all areas.

Chief Medical Director's response to Recommendation No.

In response to a need for more space, several projects are underway at VAH, Fayetteville. Included in the approved projects are: Renovation of wards at a cost of $988,000; Pre-Engineering Supply Warehouse at an estimated cost of $300,000 and a Mental Health Clinic project at a cost of $50,000.

ID No. 20

April 16, 1982

VAMC Director Comment: Mr. B. E. Phillips **indicated that this(these) project is necessary because:**

In order to maintain a quality of health care service, it will be necessary to construct additional clinic space. This facility has been without needed space since the inception of the Ambulatory Care program in 1972. When space is expanded this will permit relocation of Laboratory, Radiology and Pharmacy in order to upgrade Surgical Service and other inpatient services.

Department Adjutant Comment: Mr. Keith Sink

Mr. Sink stated he was not familiar with the project at Fayetteville VAMC, but has heard it discussed by members of the Veterans Rehab. Comm. He fully supports the addition as he feels those Legionnaires of the State who are supportive, know the needs.

Department Service Officer Comment: Mr. Paul L. Blake

Mr. Blake is away on vacation until April 20, 1982.

ID No. 21

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Fresno, CA	6	570-019	Clinical Addn. (Dental, Surg., RMS, etc.)	11/82	10,000

American Legion Field Report No. 1-034

Visitation Dates: July 13-17, 1981

Space & Construction Needs: Both JCAH and SERP have pointed out the need to expand RMS to include occupational and corrective therapies. However, neither the size of the RMS staff nor the scope of its services can be increased until additional space becomes available. The Acting Chief of Medicine was critical not only of the physical lax out of the ICU, but also of the fact that medical ans surgical patients are treated on the same unit...they have much different needs. Deficiencies in space were noted throughout the Medical Center. Medical supplies and equipment must be stored in the hallways of some of the wards because of the lack of adequate storage space.

... A proposal for the construction of a new Clinical Addition will provide the needed space for expansion of RMS and a separate SICU. This new facility will also help to alleviate the numerous other deficiencies in space ...

Recommendation No. 2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director continue to support the funding and construction of the new Clinical Addition as outlined in VAMC Fresno's Five Year Facility Plan.

Chief Medical Director's response to Recommendation No.

12/81 Response: A major construction project is programmed in a future budget year to construct two additional floors in the outpatient facility. Central Office funding to accomplish the necessary construction will be made available to the extent resources are available and within the priorities determined for the VA medical care system.

ID No. 21
April 20, 1982

VAMC Director Comment: Mr. Mason 4/13/82 **indicated that this(these) project is necessary because:**

The Director reiterated the reasons for the importance of the projects as stated in the Legion Visitation Report (stated under space and construction needs). Also, he added that there could be a slight expansion of the Audiology and Speech Program. Recently, an architectural team sent from Central Office visited the facility and renewed the construction plan. The status of the Clinical Addition officially is that it is still on schedule though this is viewed with some skepticism. Critical space problems exist for storage and a request has been submitted for a warehouse.

(NOTE): The Director made a referral to Dolly Whitehead, his Special Assistant. She related that there are critical space shortages necessitating Administrative offices being in outlying buildings. She reiterated that JCAH and SERP have cited space deficiencies in RMS and Lab. The Clinical Addition will incorporate MAS, Prosthetics, Cardiac Rehab and Psychology Rehab (biofeedback equip) also. An important aspect is the space allotted to RMS. This is the only VA facility between Los Angeles and the Bay area, and a higher percentage of patients with disabilities eg strokes are seen. These patients require more extensive training. These factors contributed to the decision to be a little beyond criteria.

Department Adjutant Comment: Mr. Donald J. Michalske 4/14/82

The Department Adjutant stated that he had recently met with Bill Sullivan, Asst. Deputy Administrator for Logistics from Central Office to renew the projects for California. He wanted to lend his support for the project and emphasize that many needs are being generated in California by the expanding aged veteran population. He had no additional comments beyond the supporting statements for this project in the Visitation Report and the Director's comments.

Department Service Officer Comment: Mr. Al Krank 4/15/82

States he lends his support to this project. Met with Dr. Walsh from Central Office to discuss projects. Feels the sizeable veteran population in California will be a strong, favorable influence in the validation of proposed scheduled projects.

ID No. 22

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Hines, IL	4	578-096	New Warehouse/Service Building	10/81	11,000

American Legion Field Report No. 2-013

Visitation Dates: April 5-8, 1982

Space & Construction Needs:

In December, the IG was on station pertaining to this project. As a consequence, this project was deferred. The IG's justification centered mainly on the need for such a large area, and two bowling alleys that were to be constructed in this warehouse. The current warehouse space is located on Loyola University property. The suggestion from the IG was to locate GSA property in the area and rent this property for two to three years. In conjunction with the expense involved, the Director is concerned about the location. It is not feasible to have a warehouse off the hospital grounds. Functions to be housed in this facility are the warehouse, supply processing and distribution, two bowling lanes, Building Management Storage and Distribution and Canteen Storage.

Chief Medical Director's response to Recommendation No.

American Legion Field Report No. 2-013 has not been completed. The approximate date of completion is May 5, 1982.

ID No. 22
April 16, 1982

VAMC Director Comment: **indicated that this(these) project is necessary because:**

This project was originally requested in 1970 at a cost of approximately $600,000.00. Currently, the estimated cost is 11 million dollars. The Inspector General's Team disagreed with certain aspects of this project, mainly the need for bowling alleys within the structure. At the present time, Government Services Administration (GSA) is looking for a building to rent to this facility for this purpose. The costs are astronomical. Approximately 37,500 net square feet are needed. The estimated rental cost is $6.50 per square foot. Additionally, the warehouse location would be too far from the hospital. Based on these figures, the annual rental fee would be $243,750.00. (The off-station location is important enough to stress again).

Department Adjutant Comment: Mr. Vincent A. Sanzotta

Referred to Department Service Officer

Department Service Officer Comment: Mr. John Cryan

Not that familiar with this project.

ID No. 23

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Hines, IL	4	578-097	HVAC Bldgs. 50, 51, 53	2/82	44,000

American Legion Field Report No.

Visitation Dates: April 5-8, 1982

Space & Construction Needs:

A recent on-site inspection of these buildings highlight the need to immediately take corrective action in this area. These buildings are 60 years old, and physically separated from the main hospital. Ideally, a new tower should be constructed to eliminate having to utilize these buildings at all. The Director agrees, but is fearful of losing the project all together. Everyone in management agrees that it would be ridiculous to spend 44 million dollars on these buildings.

The main point is to get Psychiatry Service (Bldg. 51) adjacent to the hospital. The Chief of Psychiatry said 60-65% of his patients have medical problems as well as psychiatric problems. This problem has been identified by JCAH and SERP on numerous occasions.

Even if these buildings were rejuvenated, their location would still present numerous problems.

Chief Medical Director's response to Recommendation No.

Response to Recommendation No. 5 - Report No. 9-055 - October 1979

"Renovation of Buildings 51 and 53 is included in an FY 1978 Advanced Planning Fund project for which design/construction will be considered in a future budget year in accordance with systemwide priorities and the availability of resources for our medical care system."

ID No. 23
April 19, 1982

VAMC Director Comment: Mr. John Fears indicated that this(these) project is necessary because:

The Director agrees with the numerous problems that exist because of the physical separation of these buildings. Although renovations are not the best route to go, it is better than nothing. Every rain storm, these buildings floor.

The ideal, and possibly the most cost effective course of action, would be to utilize this money to construct a tower next to the main hospital. The Director proposes the construction of a comprehensive Rehabilitation Tower in lieu of renovating the 50's buildings.

Department Adjutant Comment: Mr. Vincent Sanzotta

Referred to Department Service Officer

Department Service Officer Comment: Mr. John Cryan

Cannot add anything to above.

ID No. 24

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Hot Springs, SD	5	579-040	Clinical Addition	8/80	14,700

American Legion Field Report No. 0-029

Visitation Dates: August 25-29, 1980

Space & Construction Needs:

OBSERVATIONS: Aside from management's concern for fiscal and personnel problems is the concern for additional space. To date, management agrees that the space shortages are the Medical Center's biggest problem. The following areas are severely affected: office space, Laboratory, Hemodialysis, Psychology and Psychiatry. A two story Clinical Addition Building, earmarked in the Five Year Plan scheduled for Fiscal Year 1983, should alleviate space problems. The most pressing need is to consolidate the functions of the Laboratory. At present, the Laboratory is located on two different floors.

RECOMMENDATION No. 1. It is recommended to the Administrator of Veterans Affairs and the Chief Medical Director that funding be guaranteed and expedited for construction of the Clinical Addition. Until the Clinical Addition is constructed, the Medical Center will suffer severe space shortages.

Chief Medical Director's response to Recommendation No. 1.

November 7, 1980

1. The need for the proposed Clinical Addition is recognized, and this is an Approved Planning Fund Project. Funding for construction will be requested in a future budget year as resources and nationwide priorities exist.

ID No. 24
April 19, 1982

VAMC Director Comment: Mr. Wheaton **indicated that this(these) project is necessary because:**

This project has been identified in the Five Year Facility Plan since 1972 and now it has been pushed back to FY '87 or later. This addition is needed to alleviate the crowded conditions in many areas and relocate those functions which have been temporarily placed in the Domiciliary.

This station is getting ready to celebrate its 75th year of operation.

Department Adjutant Comment: Mr. Maynard Hemp

The Adjutant feels that the cuts in construction funds are meaningless. Everything should be restored. No portion of any facility should be diminished. With the great influx of veterans into the hospital's catchment area, he cannot imagine reducing any facility or construction projects.

Department Service Officer Comment: Mr. Ray Asmussen

Mr. Asmussen stated that each service has problems at this facility. The Clinical Building Addition would allow consolidation of medical services that are located throughout the Hospital and the Domiciliary.

ID No. 25

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Lake City, FL	3	594-036	OP & Clinical Addition	8/82	6,000

American Legion Field Report No. 2-003

Visitation Dates: January 18-22, 1982

Space & Construction Needs:

The immediate need for additional space was obvious throughout the hospital. Management reported that a proposal has been submitted for a Clinical Support Building to be built in FY 84 or early in FY 85. This project has been proposed and postponed on several occasions. Numerous services, presently critically short of space, will be affected if this building is constructed. Virtually all the space shortages experienced by this facility will be corrected with this building.

Pharmacy - critically short of space - (9000 sq. ft. short). Even though this building is on line for late 84 or early 85, previous postponements have caused even the optimists to have their doubts.

Recommendation No. 1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director expedite the construction of the proposed Clinical Support Building.

Chief Medical Director's response to Recommendation No. 1

None to date.

ID No. 25

April 15, 1982

VAMC Director Comment: Howard Ruppen **indicated that this(these) project is necessary because:**

of critical space shortages throughout this facility. This addition will also allow implementation of the Unit Dose Distribution System for Pharmacy Service. The Director is optimistic that the revalidation process will only highlight this need.

Department Adjutant Comment: Mr. Dyke E. Shannon

Mr. Shannon suggested I contact Mr. Erskine.

Department Service Officer Comment: Mr. Robert R. Erskine

Space has always been a problem at Lake City. Waiting space is extremely limited. As outlined in American Legion Report No. 2-003, page 8, "without sufficient space, even the most dedicated health care personnel cannot prevent patient care from deteriorating."

ID No. 26

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
22	Leavenworth, KS	5	686-062	Fire and Safety Improvements (Exits and Sprinklers)	3/82	7,500

American Legion Field Report No. 0-046

Visitation Dates: December 8-12, 1980

Space & Construction Needs:

No mention of this project in the Survey Report.

Chief Medical Director's response to Recommendation No.

No response from Chief Medical Director in regard to this project.

ID No. 26
April 20, 1982

VAMC Director Comment: Ms. Margaret Michelson indicated that this(these) project is necessary because:

Fire and Safety Improvements to Bldgs. 29, 88 and 100
Emergency Lighting to Bldgs. 1, 2, 3, 4, 6, 7, 9, 10, 11, 12, 13, 14 and 100
Replace Elevator in Bldg. 88
Tuck Point to Bldgs. 1, 2, 3, 4, 6, 11 and 14
Exhaust Hood/Dry Chemical System in Bldgs. 1, 2, 7, 89
Replace Walk-in Cooler

Department Adjutant Comment: Mr. Floyd J. Rogers

Was unavailable for comment.

Department Service Officer Comment: Mr. Kenneth L. Harms, State Service Director Comment:

Sees no reason why this project should be revalidated.

ID No. 27

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
22	Leavenworth, KS	5	686-060	208 Domiciliary	7/81	14,900

American Legion Field Report No. 0-046

Visitation Dates: December 8-12, 1980

Space & Construction Needs:

DOMICILIARY: A 208 Bed Domiciliary Addition has been proposed for Fiscal Year 1983 and is included in the Five Year Facility Plan. The present plan is to retain the present bed consus, but close two of the Domiciliary Units

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Chief Medical Director's response to Recommendation No.

No response from the Chief Medical Director in regard to this project.

ID No. 27
April 19, 1982

VAMC Director Comment: Ms. Margaret Michelson**indicated that this(these) project is necessary because:**

The existing buildings will be 100 years old in 1986. A tremendous amount of work goes into these buildings to maintain them. The new Domiciliary will be a great asset, and reduce the maintenance on the older buildings.

Space is a problem. Although there is plenty of it, it is adjacent to the wrong areas.

When JCAH surveyed this hospital in the summer of 1980, they made recommendations pertaining to the Domiciliary operations. No citations were made regarding the physical plant because the new facility was listed on the 5 Year Plan. It may not happen again when they visit this summer.

Department Adjutant Comment: Mr. Floyd J. Rogers

Was unavailable for comment.

Department Service Officer Comment: Mr. Kenneth L. Harms, State Service Director:

The buildings at this facility are very old. They look good from the outside, but need a lot of interior redesigning. The addition would be very beneficial to all concerned.

ID No. 28

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Livermore, VA	6	599-054	Fire & Safety Improvements	7/82	3,500

American Legion Field Report No.

Visitation Dates:

Space & Construction Needs:

No mention was made of these projects in the visitation report.

Chief Medical Director's response to Recommendation No.

No response in regard to this project.

ID No. 28
April 16, 1982

VAMC Director Comment: Mr. O'Rear-4/14/82 **indicated that this(these) project is necessary because:**

This project is for safety deficiencies that have been cited 7 to 8 years ago. Two service elevators and dead end corridors presenting exit problems are identified areas for improvement. $6 million was estimated as the current cost. These areas have been cited by JCAH but they visited in Nov. '81 and word was received in March '81 that a 2 year accreditation has been approved. The Director indicated that there are current space deficiencies. For several months a master survey of the entire facility has been conducted to determine whether there is a shortage of space or mal use of it. Results should be known by the end of April. There is an ongoing construction project on the 5th floor involving Respiratory Care beds and additional medical beds which will relieve some current congestion. There has been no recent visit by the Inspector General.

Department Adjutant Comment: Mr. Donald J. Michalske 4/14/82

Stated he wanted to emphasize the growing needs in California due to the increasing population of aged veterans. Lends his support to this project. Met with Mr. Sullivan from Central Office to discuss California projects. Has no additional comments beyond the supporting statements of the Director's comments.

Department Service Officer Comment: Mr. Al Krank

Stated that he met briefly with Dr. Walsh from Central Office regarding California projects. States he lends his support and feels that the sizeable veteran population in California will be a favorable influence in the validation of scheduled projects.

1D No. 29

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Loma Linda, CA	6	605-004	60 bed N.H.C.U.	10/82	6,000

American Legion Field Report No. 0-016

Visitation Dates: May 22-28, 1980

Space & Construction Needs:

A 60 bed N.H.C.U. is located on two ward areas on the first floor with convenient access to three garden areas.

Plans for the future will be to increase the number of beds for this unit.

Chief Medical Director's response to Recommendation No.

August 13, 1980	No response received in regard to an additional 60 bed N.H.C.U.

VAMC Director Comment: Mr. Martano-4/14/82 **indicated that this(these) project is necessary because:**

The Director stated that being a new hospital there are no major space problems. He feels the Medical Center is just beginning to reach its potential. At present they are operating at an 80% occupancy rate.

The Director does not feel that the 60 N.H.C.U. project is in jeopardy and that it will remain on line.

He related that there were no pertinent citations from JCAH nor any recent visit from the Inspector General.

Department Adjutant Comment: Mr. Donald J. Michalske-4/15/82

States he recently met with Mr. Sullivan from Central Office to review the California projects. Lends his support to the scheduled projects and wants to emphasize the needs being generated in California by the growing aged veteran population.

Department Service Officer Comment: Mr. Al Krank-4/15/82

States he met briefly with Dr. Walsh from Central Office regarding California projects. Lends his support to these projects. Feels the sizeable veteran population in California will be a strong favorable influence on the validation of scheduled projects.

ID No. 30

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Los Angeles, VA (WAD)	6	691-090	Renovate Bldgs. 212, 214, & 217 for Dom.	9/81	17,300 (est. 3-4 yrs. ago)

American Legion Field Report No. 1-028

Visitation Dates: June 8-12, 1981

Space & Construction Needs:

The early 1930 Domiciliary bldgs. are scheduled for total renovation commencing in FY '83. Currently, two bldgs. are utilized for the purpose of housing 400 members. Upon completion of the renovation projects, three bldgs. will be available and the total authorized beds will be reduced to 350.

The project will allow for more living space for the members with a maximum of four members per room. (Currently, large bays with a common bathroom are utilized). Consequently, upon completion of this project female veterans can be accommodated. Other improvements include: air conditioning, new elevators, a laundry room and a little kitchen on each floor, three multi-living units for married veterans, and most important, a dining room for Dom. members. The unpleasant arrangement of busing members to VAMC Brentwood 3 times a day, 7 days a week for meals can be discontinued upon completion of the project. Recommendation No. 5. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director continue to monitor the planned Domiciliary Renovation projects to insure that they will be fully funded and constructed as scheduled for FY '83.

Chief Medical Director's response to Recommendation No.

12/81 Response to Recommendation No. 5. ......renovation of Building 215 and 213 to NHCUs and renovation of the Domiciliary bldgs. are projected in the facility's long-range comprehensive plan for accomplishment in future budget years. However, the uncertainty surrounding our budget prevents us from pinpointing a specific date for their achievement.

VAMC Director Comment: Mr. Anderson-4/14/82 **indicated that this(these) project is necessary because:**

The Director confirmed the facts in the June '81 Legion Visitation. Also, he added that busing veterans for meals puts a restriction on candidates for the Dom because those in wheel chairs can't be considered because they can't be accommodated for meals. The Director stated that if he had to prioritize the two projects at WAD, he would emphasize the Dom renovation because 120 NHCU beds are on line for '83. There is a problem with doing both the Dom renovation and the NHCU conversion, phase II (bldg. 213) in '84 because one of the bldgs. will be needed to cycle patients during the construction work in the other. Dr. David West from Central Office has visited this week regarding the revalidation of the project. The Director stated he showed him the bldgs. and discussed alternatives but was given no feedback.

Department Adjutant Comment: Mr. Donald J. Michalske 4/14/82

Adjutant Michalske stated the need for the California projects especially in light of the growing aged veteran population on the West Coast. He related that he had met with Mr. Sullivan from Central Office and reviewed the projects. He had no other additional comments beyond the supporting need statements of the Visitation Report and the Director's comments.

Department Service Officer Comment: Mr. Al Krank 4/15/82

The Department Service Officer states that he lends his support to these projects. He related that Dr. Walsh visited on Monday 4/12/82. The Department Service Officer stated his feeling that the sizeable veteran population in California will be a favorable factor in the validation of scheduled projects.

ID No. 31

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Los Angeles, VA (WAD)	6	691-098	120 Bed NHCU (conversion) Bldg. 213 (phase II)	3/82	10,500

American Legion Field Report No. 1-028

Visitation Dates: June 8, 12, 1981

Space & Construction Needs:

The establishment of Nursing Home Care Unit (NHCU) beds at VAMC Wadsworth at Los Angeles has been promised many times. Finally, plans for FY '82 indicate that bldg. #25 will be converted to allow for 120 NHC beds. During FY '83 another 120 beds will be realized with the conversion of bldg. #213.

Recommendation No. 3. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director continue to monitor the planned Nursing Home Care projects to ensure that they will be fully funded and constructed on schedule for FY '82 and FY '83.

Chief Medical Director's response to Recommendation No.

12/81 Response to Recommendation Nos. 3 and 5: ...renovation of Building 215 and 213 to NHCUs and renovation of the Domiciliary bldgs. are projected in the facility's long-range comprehensive plan for accomplishment in future budget years. However, the uncertainty surrounding our budget prevents us from pinpointing a specific date for their achievement.

ID No. 31
April 19, 1982

VAMC Director Comment: (Mr. Anderson) **indicated that this(these) project is necessary because:**

4/14/82 - The Director described the projects as a two-phase project eventually giving the VAMC 240 NHCU beds. There are two bldgs. side-by-side built in 1942 which need renovation. Approval for bldg. 215 (120 beds) has been given for '83 and is on line, while the second bldg. 213, is scheduled in '84.

The need for the NHCU beds is based on placement needs. At present, 115 veterans are placed in community nursing homes and the cost of this continues to rise. Availability of placement is sporadic. Being a Med/Surg facility with specialties such as open heart surgery, the Director indicated that Wadsworth receives many patients needing placement.

As indicated in the renovation project for the Dom, the Director if he had to prioritize the two projects emphasizes the Dom renovation because 120 NHCU beds are on line for '83. He indicated a problem with doing both construction projects in '84 for Dom and NHCU because one bldg. is needed for cycling patients while the other is having construction.

Dr. David West from Central Office visited this week regarding the revalidation of this project. The Director stated he showed him the bldgs. and discussed alternatives but was given no feedback.

- Department Adjutant Comment: Mr. Donald J. Michalske 4/14/82

Extended his support for the project. States he wanted to emphasize the growing needs in California due to the increasing population of aged veterans. States that he had met with Mr. Sullivan from Central Office to discuss the projects. He had no additional comments to make beyond the support statements on the Visitation Report or the Director's comments.

Department Service Officer Comment: Mr. Al Krank 4/15/82

Mr. Krank stated that he lends his support to the project. He had a chance to briefly meet with Dr. Walsh from Central Office on 4/12/82. Mr. Krank's feeling is that the sizeable veteran population in California will be a favorable factor in the validation of scheduled projects.

ID No. 32

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Lyons, NJ	4	604-046	120 bed N.H.C.U.	8/82	15,200

American Legion Field Report No. 1-029

Visitation Dates: June 22-26, 1981

Space & Construction Needs: This 90 bed Nursing Home Care Unit was opened in 1974. Word has been received that VACO has authorized and will provide the necessary funding for the construction of a new 120 bed N.H.C.U. When the unit is complete the Medical Center will have a total of 210 N.H.C.U. beds.

Recommendation No. 1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director continue to support and fund those construction and renovation projects outlined in VAMC Lyons' Five Year Facility Plan.

Chief Medical Director's response to Recommendation No. 1. We will continue to plan and fund projects that are consistent with systemwide priorities and budgetary constraints.

ID No. 32
April 15, 1982

Acting
VAMC Director Comment: Mr. Reedes Hurt indicated that this(these) project is necessary because:

The demands for N.H.C.U. is so overwhelming that sufficient beds are not available to meet the demands. It would be misleading to veterans to place them on a waiting list, knowing full well that they could not be admitted. In order to meet future demands more beds must be constructed.

Department Adjutant Comment: Mr. Robert Field

The Adjutant is on vacation and will not return to his office until April 19, 1982.

Department Service Officer Comment: Mr. Thaddeus J. Gnidziejko

The Department Service Officer supported the need for more N.H.C. beds because of the many demands for such care. He feels that with the increasing age of veterans, more facilities of this type will continue to be needed. Waiting lists are by no means a method of successful operation as beds are not now available for such care.

ID No. 33

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
I	Manchester, NH	1	608-014	Laundry, Warehouse, Engineering Facility	10-82	10,000

American Legion Field Report No. 6-144

Visitation Dates: December 6-10, 1976

Space & Construction Needs:

ENGINEERING SERVICE:

Shortage of floor space is Engineering Service's greatest problem. The current deficiency is 10,000 square feet. If the new shop and Laundry Building is approved, these deficiencies will be eliminated.

Chief Medical Director's response to Recommendation No.

The Chief Medical Director did not include this project in his response on February 1, 1977.

ID No. 33
April 19, 1982

VAMC Director Comment: Mr. Delbert Nutter indicated that this(these) project is necessary because:

Space is needed in the hospital. The Laundry would move out and the Lab would move in. Storage areas would improve greatly. Currently, 5 semi's have been borrowed from the USAF for storage. Other areas of shortage affected by this construction are: Engineering, Paint Shop, Lab, SDP, Respiratory Care, Dental, Library, Occupational and Physical Therapy, and Storage and Dietary and Pharmacy. In July 1981, JCAH cited Rehab. Medicine for patient care space and waiting space in Radiology.

Department Adjutant Comment:

The Department Adjutant died recently and his replacement was not familiar with the project.

Department Service Officer Comment: Mr. Keith G. Fleury

This project is greatly needed. The Laundry also does the White River, Vermont laundry. The current equipment is antiquated. There are some areas that are very cramped (offices, storage, Canteen).

ID No. 34

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Martinez, CA	6	612-018	120 Bed NHCU	6/82	14,400

American Legion Field Report No. 1-035

Visitation Dates: July 20-24, 1981

Space & Construction Needs:

The lack of adequate space is another resource deficiency that has been noted through this Report. Growth to meet patient care demand would be almost impossible under the current constraints.

Chief Medical Director's response to Recommendation No.

No recommendation made.

VAMC Director Comment: Mr. Nixon 4/15/82 **indicated that this(these) project is necessary because:**

The Director stated that the proposed 120 bed NHCU was not a Medical Center originated project but rather a Central Office initiated project. The need is based on projected population, and the difficulty and high cost of community NHC placement. Since the Medical Center is tight on land there is a question of whether the construction can be accomplished without the additional purchase of land whose cost has been built up. There is consideration that it would be better to put the 120 beds additionally at Livermore. The Director believes that there is no basis for not concurring with using Livermore, and that there are pros and cons to this issue with it being a matter of preference rather than substantive issues. While he considers both alternatives viable, he stressed his main concern is a major $25-$30 million major project for a facility addition and renovation at Martinez which is to be funded in FY '84. The Director states his facility is 50% under spaced. It was a suburban, non-teaching Medical Center 7 years ago but now is fully affiliated and has instituted numerous patient care programs. He believes the facility was never properly planned for this change in mission, compounded by the total inability to get any construction to alleviate the consequent needs of expansion. Needs are identified as great and the proposed major construction ties in with accreditation and is intended to correct space deficiencies, provide for patient privacy, and eliminate fire and safety deficiencies. Space is so cramped that Administrative offices are in trailors around the hospital. The Director believes that there may be some merit to revalidating some construction projects because the criteria for establishing space needs has been unrealistic. He feels the criteria needs to be revalidated and space planning has to be examined for best use of the dollar.

Department Adjutant Comment: Mr. Donald J. Michalske 4/14/82

The Adjutant stated he was aware of a potential problem with the NHCU because several months ago the VA Administrator had inquired about the VA buying contiguous land to the present facility but the owner's had jacked the price. He voiced his support for meeting the needs of California's expanding veteran population.

Department Service Officer Comment: Mr. Al Krank 4/14/82

Met briefly with Dr. West from Central Office regarding the construction projects. States his support and feels the sizeable veteran population will be a favorable factor in considering completion.

ID No. 35

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Miami, FL	3	546-014	120 bed N.H.C.U.	8/82	16,000

American Legion Field Report No. 1-039

Visitation Dates: August 24-28, 1981

Space & Construction Needs:

Statistics indicate that approximately 5000 veterans are moving to Florida every month. A recently constructed N.H.C.U. consisting of 120 beds was built with the capability of adding 120 more beds in the future.

Recommendation No. 4. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director provide funding and staffing for the proposed 120 additional Nursing Home Care beds.

Chief Medical Director's response to Recommendation No. 4

"A 120 bed two story addition to the existing nursing home building is included in the Fiscal Year 1984 plan for design/construction. The tentative completion date is October 1986. Funding and staffing will be made available when the unit is activated."

ID No. 35
April 15, 1982

VAMC Director Comment: Thomas Doherty **indicated that this(these) project is necessary because:**

The need for additional Nursing Home Care beds has always existed in Florida. A new 120 bed unit was recently completed. The building was constructed with the intention of adding two more stories (120 beds). The constant flood of veterans to Florida is no secret. The VAMCs in Florida are fast becoming crowded with no relief in sight.

Department Adjutant Comment: Mr. Dyke E. Shannon

The need for Nursing Home Care beds, especially in the Miami area, is a need that must be addressed if the VA is to continue providing care to the aging veterans.

Department Service Officer Comment: Mr. Robert R. Erskine

Agrees with what seems like an obvious need. Mr. Erskine mentioned American Legion Report No. 1-039, page 8, which said basically that the new 120 bed unit is under-utilized because of insufficient staff.

ID No. 36

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Minneapolis, MN	5	615-001	Replace Hospital Buildings.	6/82	294,000

American Legion Field Report No. 0-19

Visitation Dates: July 14-18, 1980

Space & Construction Needs: Many construction projects have been placed in a holding pattern, pending a new replacement hospital. The Outpatient Clinic is located at Ft. Snelling to provide eye, ear, nose and throat clinic and compensation and pension examinations. Other clinics are located throughout the hospital in order to maintain timely service to outpatients. It is anticipated that the total number of outpatient visits for Fiscal Year 1980 will exceed 220,000.

Recommendation No. 3. It is recommended that the Administrator of Veterans Affairs continue support of the planned replacement hospital with 845 beds. NOTE: At the 59th Annual Natl. Convention of The American Legion, Denver, CO, August 23-24,25, 1977, Resolution No. 383 (Minnesota) - Subj. Urged the construction of a new VA Hospital in Minneapolis, Minnesota, to replace the existing facility - The resolution was to the Standing Commission on Veterans Affairs and Rehabilitation.

Chief Medical Director's response to Recommendation No. Letter signed by Chief Medical Director dated November 3, 1980.

Recommendation No. 3. The VA is proceeding with plans to construct a replacement Medical Center at Minneapolis which will provide 725 hospital beds and 120 nursing home care beds.

ID No. 36
April 19, 1982

Ms. Shelia Cullen, Exec. Asst. to the Director

VAMC Director Comment: indicated that this(these) project is necessary because:

They feel that because of the age of buildings, the lack of private bath and toilet facilities and the 16 bd. wards, that these conditions are not conducive to good private health care. The IG team was there 2 months ago and were bias toward renovation of some buildings and replacing some. The fact remains that plans are so far advanced toward a new hospital that new work would have to begin all over to redesign plans. Not only would this delay the process but costs would be higher. Operating 2 separate Outpatient Clinics causes loss of records, duplication and delays.

Mr. Charles Ferguson on Apr. 16, 1982 outlined the following reasons for replacing the VAMC Minneapolis, Minnesota.

Department Adjutant Comment: 1. The present facilities are outdated to provide good, safe health care. 2. These conditions have existed for 15 years and numerous studies have been made to try and correct. Renovation of the present buildings was considered and studies indicated that replacement costs would only exceed renovation cost by 1 million dollars. 3. Minneapolis VAMC not only serves veterans in Minnesota but also parts of S. Dakota, N. Dakota, Western Wisconsin, Iowa, 2 counties in Montana and 2 in Wyoming. 4. We do not believe that surplus beds in the private sector are suitable to serve the needs of our aging veteran population as many are maternity beds and not that many exist. 5. If the Dept. of Defense expects support from the VA, the present facility must be replaced.

Department Service Officer Comment: Mr. Michas Olmstad was contacted on Apr. 16, 1982. His comments are as follows: The American Legion of Minnesota has and will continue to support this project as a forefront priority. All criteria to show need for a new hospital have been met. The work load, veteran population and all has been met. There is no valid reason why the project should not proceed. From the standpoint of economy, it is not feasible to continue to subject veterans to conditions that now exist. The distance between the outpatient and inpatient services require too much time for both veterans and personnel. All service organizations fully support the project and The American Legion feels all opposing challenges have been met.

ID No. 37

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Montgomery, AL	3	619-020	OPC Addition	9/80	18,100

American Legion Field Report No. 9-030

Visitation Dates: July 16-19, 1979

Space & Construction Needs:

An Ambulatory Care Building is in the planning and development stages. This building is needed to relieve space deficiencies throughout the Medical Center and eliminate the need for 3 quonset huts. Services that would be relocated if this building were constructed are: Pharmacy, Laboratory, PAD, Prosthetics, Voluntary, Canteen and Radiology. Services that would be expanded are: Education, Rehabilitation Medicine, Dental, Security and Medical Administration. Prompt Central Office action is needed on this $7.6 million construction project. (Cost now estimated at 18,100,000).

Recommendation No. 1. It is recommended that the Chief Medical Director approve the construction of the Medical Facility Improvement (Ambulatory Care Building) project that is pending in Central Office.

Chief Medical Director's response to Recommendation No. 1.

"The project for construction of an Ambulatory Care Building at Montgomery is being developed through the FY 1978 Advanced Planning Fund and is not proposed for construction funding through FY 1981. Construction will be proposed for a future year in accordance with systemwide priorities and the availability of resources for the medical care system."

ID No. 37
April 15, 1982

VAMC Director Comment: Floyd C. McNair indicated that this(these) project is necessary because:

it will eliminate virtually every space problem presently experienced by this facility. Additionally, it will eliminate the need to utilize the 3 quonset huts currently being used for Prosthetics Service, Canteen, and Record Storage. This facility is facing a desperate space situation. On the 28th of this month, 3 personnel from VACO are expected to arrive for the purpose of revalidating this project.

Department Adjutant Comment: Mr. Melvin Hudson

Concurs with Director's comments.

Department Service Officer Comment: Mr. Charles Boles

Not available until Monday.

ID No. 38

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
2	Newington, CT	1	627-032	Addition to Bldgs. 1 & 2	4/80	45,000

American Legion Field Report No. 9-038

Visitation Dates: July 16-20, 1979

Space & Construction Needs: OBSERVATIONS: Spacial problems abound at this Medical Center. The most critical is the overcrowded outpatient area. The waiting room is not sufficient and many patients have to stand waiting to see a doctor. Storage and office space are at a premium. Many doctors offices have multipurpose uses. Storage of equipment in hallways is not uncommon throughout the hospital.

COORDINATION: The new addition to Bldg. 1 is slated for construction in FY '81 according to the Facility 5 Year Plan.

PHARMACY SERVICE: A recent survey revealed that this service was deficient 6,741 square feet.

RECOMMENDATIONS: (1) It is recommended that the VA Administrator and the Chief Medical Director expedite the addition to Bldg. 1 as outlined in the Facility 5 Year Plan.

(4) It is recommended to the Chief Medical Director that expansion of the Pharmacy be provided.

Chief Medical Director's response to Recommendation No. 1. Preliminary plans are being developed by an architect engineer firm contracted by VACO.

October 10, 1979

4. Additional space has been added by medical facility level projects, and more space is included in the major construction project now being developed as stated in Recommendation No. 1.

ID No. 38

April 16, 1982

VAMC Director Comment: Maurice A. Holton **indicated that this(these) project is necessary because:**

There is good justification for this project. It has been in active design for 3 years. The preliminary plans are 98% complete. This project is a combination of projects. Bldg. 2 was the original, and was to address the shortages in Ambulatory Care and Support Service. Then the Bldg. 1 addition was added to provide patient privacy, better Ancillary Services space, and air conditioning and sprinklers. Also, with Bldg. 1, is a new O.R. suite which has been identified by the VA as being below standards. Other areas to be aided by the new additions are: Pharmacy, SPD, and Alcohol Outpatient follow-up. JCAH's visit in October 1981 was followed by a 1 year Accreditation. There were many minor citations. One dealt with dead end corridors. This would be rectified with the project. There were also areas mentioned that had space shortages, but not cited.

Department Adjutant Comment: Mr. Hugh C. Graham

There is a need for more patient space. There has been a lot of internal remodeling. A large auditorium used for bingo and other patient activities has been eliminated.

Department Service Officer Comment: Mr. Benjamin B. Truskoski

He stated he has been out sick and is unfamiliar with the project, but feels they could use the space. He said that the DAV is pushing for a new facility on the grounds at the University, but he feels that even though it is an old facility it is well maintained.

ID No. 39

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
3	New York, NY	1	630-025	Upgrade Electrical Distribution, Phase II	10/78	4,000

American Legion Field Report No. 9-051

Visitation Dates: September 24-28, 1979

Space & Construction Needs:

CONCLUSIONS

During this Survey, it was quite apparent more space is needed for both staff and patients. Certain areas, i.e., chest surgery are in particular critical need of additional space. Waiting areas, i.e., Ambulatory Care and Psychiatric Screening, are also limited in space.

----------- This is not related to the above project, -------------- it just identifies spacial needs.

Chief Medical Director's response to Recommendation No.

No response from Chief Medical Director regarding the project.

ID No. 39
April 19, 1982

VAMC Director Comment: Mr. James S. Dooley indicated that this(these) project is necessary because:

This is a cost savings and control of system project that is a VACO concept. Con-Edison owns the 5 transformers supplying the VAMC. It is low voltage and the hospital has to increase it to meet their needs. The project will allow high voltage to meet the needs and the transformers will be government owned.

Department Adjutant Comment: Mr. Leonard E. Baxter

Feels it is needed to help reduce costs. The longer you wait, the more it will cost to complete.

Department Service Officer Comment: Mr. Douglas A. Wheat

He is not familiar with the project, but has no disagreement with its completion. He is familiar with Con-Edison though.

ID No. 40

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
3	Northport, NY	1	632-062	120 Bed NHCU	9/82	13,800

American Legion Field Report No. 0-035

Visitation Dates: September 22-26, 1980

Space & Construction Needs:

SOCIAL WORKPSERVICE

This service is funded for only 20 community placements. According to the Chief of Social Work Service, this number is grossly inadequate. Additional authorized placements would not alleviate the problem because: (1) The lack of nursing homes in the area - (2) Private pay and Medicare patients are given preference. (Both these groups can be charged more).

CONCLUSIONS

Reiterates the statements made under Social Work Service.

RECOMMENDATIONS

1. It is recommended to the Administrator of Veterans Affairs and to the Chief Medical Director that funds be provided for the construction of a NHCU at this Medical Center.

Chief Medical Director's response to Recommendation No. 1, 2 and 3:

February 9, 1981

Both the 120 Bed NHCU and the new Outpatient Clinic Building are included in the Facility's long-range comprehensive plan and will be considered for design and construction as funds become available in future budget years. The SICU is an approved minor construction project for FY '81.

ID No. 40

April 19, 1982

VAMC Director Comment: Wm. L. Hodson, Jr. **indicated that this(these) project is necessary because:**

There are approximately 400,000 veterans located on Long Island. Many of them are nearing the age when nursing home care will be needed. The nearest NHCU is located at St. Albans (Brooklyn) VAMC. It consists of 230 beds and has a waiting list of approximately 300.

A team from VACO is currently (4-15-82) at the hospital looking at the project to check it for design criteria.

Department Adjutant Comment: Mr. Leonard E. Baxter

This Medical Center serves the entire metropolitan area. This project is direly needed for these veterans.

Department Service Officer Comment: Mr. Douglas Wheat

Nursing home care beds in New York State are needed badly. Over 200 veterans are waiting to get into the NHCU in Brooklyn. This project is direly needed.

ID No. 41

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Omaha, NE	5	636-022	OPC Addition	9-80	24,200

American Legion Field Report No. 1-063

Visitation Dates: December 7-11, 1981

Space & Construction Needs:

OBSERVATIONS: The need for additional space has been recognized and justified since 1974. The most acute need is within the Ambulatory Care and Admissions area. Sufficient waiting areas, nursing space, and an adequate number of examination rooms are non-existent. Inadequate space lends itself to having to compress activities and fast shuffling. Unfortunately, a lot gets lost in the extremely fast shuffle. Tentative plans for a Clinical Addition are outlined in the Five Year Facility Plan for FY '83. Because of previous postponements, Medical Center management is leary about this urgently needed project being awarded in FY '83.

ADMISSIONS, OUTPATIENT CLINIC, AND AMBULATORY CARE SERVICE: Until the proposed Clinical is realized, this service cannot function as efficiently as it should. Waiting areas are virtually non-existent. Nursing space is limited and an insufficient number of examination rooms increases processing time and causes unnecessary delays.

CONCLUSIONS: The proposed Clinical Addition, which includes extensive renovations of the first floor, is slated for FY '83. Judging from the level of activity currently taking place in such a confined space, this appears to be the absolute latest date this project should be started. Any future postponement cannot help but affect patient care in the negative sense.

RECOMMENDATION No. 1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director continue to monitor the proposed Clinical Addition to ensure it proceeds on schedule.

Chief Medical Director's response to Recommendation No.

The Chief Medical Director has not responded to this Field Report.

ID No. 41
April 19, 1982

Assistant
VAMC Director Comment: Mr. Steven Gentling **indicated that this(these) project is necessary because:**

of the serious space deficiencies that it will correct. As outlined in American Legion Report No. 1-063, this project was originally slated for FY '83. Last August, an IG team spent 3 weeks at the hospital and consequently moved the project to FY '84. This team further proposed cutting the scope of this project in half. As of late, a good deal of communication with VACO has been generated pertaining to this project. Last week, the Medical Center forwarded a package of information to Central Office, in regards to this project. This need has been identified and justified since 1974.

Department Adjutant Comment: Mr. Duane Bokemper

Nothing to add that wasn't in The American Legion Report No. 1-063.

Department Service Officer Comment: Mr. Jim Hurlbert

Supports the need for this urgent project. Mr. Hurlbert said that the veterans are stumbling all over each other in the Outpatient Clinic area.

ID No. 42

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Perry Point, MD	2	641-079	New Laundry Building	8/82	18,500

American Legion Field Report No. 0-014

Visitation Dates: June 2-6, 1980

Space & Construction Needs:

The laundry facility is responsible for VAMC Perry Point, as well as for four other VA Medical Centers. Storage is so limited that supplies must be transported to and from the main warehouse. This is both insufficient and inconvenient. According to the Five-Year Facility plan, construction of a new laundry building is slated to begin in FY 81.

Chief Medical Director's response to Recommendation No.

1. A new laundry building is planned for construction in a future fiscal year.

ID No. 42

April 14, 1982

VAMC Director Comment: Mr. Robert Dawson indicated that this(these) project is necessary because:

Currently this laundry is processing 6 million pounds of laundry per year for 5 Medical Centers. It is anticipated that this work load will increase to approximately 8 million pounds by FY 1985. New pieces of equipment are being placed into use periodically but this does not alter the need for a new building. This project is high on the approved list in Central Office and no reason is seen why it will not be completed. It will continue to be necessary to replace equipment until such time as a new building is constructed.

Department Adjutant Comment: Mr. Robert Ford supports the proposal for a new laundry facility at Perry Point as he has some understanding of its need.

Department Service Officer Comment: Mr. Earl Wright

Not available for comment since he is on Sick Leave.

ID No. 43

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Pittsburgh, PA University Drive	2	646-024	O.P.C. Addition	2/82	24,200

American Legion Field Report No. 9-002

Visitation Dates: Jan. 29-30-31, Feb. 1-2-8-9,1979

Space & Construction Needs: Space deficiencies exist in clinic areas, Pharmacy and Ambulatory Health Care Service. Future plans call for elimination of these deficiencies by construction of a Clinical Building.

RECOMMENDATION No. 1. It is recommended to the Administrator of Veterans Affairs and the Chief Medical Director to assert their best efforts to secure funds to construct a Clinical Building adjacent to the Medical Center. This should be sufficient to house all outpatient activities along with needed support services, thus freeing up space within the hospital to expand inpatient care. Additional parking space could be made available in the construction of this support building.

Chief Medical Director's response to Recommendation No. 1. Concerning construction of a Clinical Building adjacent to the Medical Center, a project has been submitted in the Facility's Five Year Plan for FY 1980 to FY 1984, which involves such services as the OR Suites, Clinical laboratories, Ambulatory Care facilities and other related activities.

ID No. 43
April 14, 1982

VAMC Director Comment: Thomas A. Gigliotti indicated that this(these) project is necessary because:

Space is currently so crowded it creates many problems in getting patients into the right areas for examination and treatment. A new Clinical Building would make space available within the hospital to expand surgery and other related programs.

Ward was received on April 13, 1982 that the Administrator has approved a 2 million dollar expenditure for designing and planning

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Department Adjutant Comment: Mr. Edward T. Hoak

A recent visit to the VAMC Pittsburgh was enough to convince the Department Adjutant that additional space is needed. He stated cars were lined up 2 blocks trying to find parking spaces, in order to enter the Medical Center.

Department Service Officer Comment: Mr. John P. Ward

It is evident that with the present work load more space for clinics is necessary. If any timely care is to be provided, more space is absolutely necessary.

ID No. 44

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Pittsburgh, PA Highland Drive	2	645-017	Laundry	10/82	12,000

American Legion Field Report No. 9-002

Visitation Dates: Jan. 29-30-31 Feb. 1-2-8-9, 1979

Space & Construction Needs:

No mention was made in the last Visitation Report concerning a need for a laundry facility.

The need for a District Laundry facility was identified in our Field Reports 5-009-1975; 6-090-1976.

Chief Medical Director's response to Recommendation No.

Reference to the need for a consolidated laundry was made in CMD Letter Dated August 24, 1976. (University Drive)

"We are aware of the critical need to upgrade the laundry equipment at University Drive. Interim funds have recently been allocated for the replacement of several items which are beyond repair. A decision about the degree of consolidation and the possible change of location of the laundry has not been made."

Reference to the need for a consolidated laundry was made in CMD Letter Dated August 24, 1976. (Highland Drive)

"Representatives of Building Management Service have conducted a review, which is still under consideration in Central Office, of the laundry consolidation in Medical District 5."

ID No. 44

April 14, 1982

VAMC Director Comment: Mr. Carl Cossu **indicated that this(these) project is necessary because:**

Currently, the laundry is being processed at the University Drive Division. This facility is located in the basement and working conditions are very undesirable. With the construction of a new laundry at Highland Drive Division, laundry will be processed for 3 Medical Centers. This will increase efficiency and reduce costs.

It is the opinion of the Director that ample justification has been provided Central Office to keep the project active and forthcoming.

Department Adjutant Comment: Mr. Edward T. Hoak

Mr. Hoak indicated support for this facility as it should reduce laundry costs and provide better service to all facilities.

Department Service Officer Comment: Mr. John P. Ward

Mr. Ward likewise supported this project and is certain working conditions will be much improved and service provided at a lesser cost.

ID No. 45

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Pittsburgh, PA University Drive	2	646-025	Centralized Warehouse Facility	10/82	4.200

American Legion Field Report No. 9-002

Visitation Dates: Jan. 29-30-31, Feb. 1-2-8-9, 1979

Space & Construction Needs:

During the time of this visit, no mention was made for a warehouse facility. In talking with the Medical Center Director on April 13, 1982, it was learned that this need has surfaced since the last Field Representative's visit.

Chief Medical Director's response to Recommendation No.

No comment from C.O. as this was not noted in Visitation Report of February 1979.

ID No. 45

April 14, 1982

VAMC Director Comment: Thomas A. Gigliotti indicated that this(these) project is necessary because:

Since Supply Service has been centralized to the Aspinwall Division for 3 separate facilities, a need exists for more warehouse space. This project is not currently listed as high on the priority lists but no mention has been made by Central Office to defer it beyond FY 1984.

Department Adjutant Comment: Mr. Edward T. Hoak

It seems reasonable to assume that some projects of this nature should be consolidated in an effort to save space and contain costs.

Department Service Officer Comment: Mr. John P. Ward

He feels certain this is a wise decision and such project could satisfactorily serve the needs of these Medical Centers.

ID No. 46

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Prescott, AZ	6	649-047	200 Bed Dom 60 Bed NHCU	3/81	30,000

American Legion Field Report No. 1-012

Visitation Dates: March 9-13, 1981

Space & Construction Needs: A project requesting a 60 bed Nursing Home Care Unit (NHCU) coupled with a new Domiciliary has been postponed numerous times over the past 6 years. In an area that attracts mostly retired veterans, there are a limited number of community nursing homes because the State of Arizona does not offer Medicaid. Local placement of veterans is virtually impossible, and the NHCU at VAMC Phoenix is not a reliable outlet because of the long waiting list that is maintained. The four separate buildings comprising the Domiciliary structure have no facilities for women, extremely old bathroom facilities, and only one building is wheelchair accessible. This project will not only furnish the desperately needed nursing home care beds, but will correct the shortcomings pertaining to the lack of rehabilitation activities for Domiciliary members as well. Another space need noted is the expansion of the Surgical Suite which is included in a project for construction in FY '85.

Recommendation No. 1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director authorize funding for the planning and construction of the Domiciliary/Nursing Home Care Unit project.

Chief Medical Director's response to Recommendation No. 1. We concur with the need for the planning and construction of a 200 bed domiciliary/60 bed Nursing Home Care Unit and such a project is scheduled for construction in FY '85.

Response October 1981

ID No. 46
April 19, 1982

VAMC Director Comment: Mr. McIntyre, 4/13/82 **indicated that this(these) project is necessary because:**

The Director states that the situation in Arizona has intensified without any improvement. They are re-assessing their needs for this project in that 60 NHCU beds may not be enough. At present there is one contract with a community nursing home which is 165 miles away. There remains a waiting list for the NHCU at Phoenix. While there is some access to contract facilities at Phoenix, there is resistance by veterans to being that far from home and their spouses are virtually deprived of the opportunity to visit. Even to do this there is a 6 month waiting list and high price range. The area is getting more veterans age 65 and older, and it is projected that the number of veterans 55 years and older will increase by 205% by the year 2000. At present the backlog is such for nursing home care beds that it seems to the Director that as many veterans are dying awaiting placement as are getting placement.

Department Adjutant Comment: Mr. Bryant B. Barron 4/13/82

The Domiciliaries are inadequate buildings constructed in 1903-1906. They would require $3 million to be seismic proof in addition to the refurbishing cost. There is a question of changing the emphasis from Dom beds to more NHCU beds in this project. At present studies are being done to determine District needs.

Since Prescott has no NHCU beds it is hoped this priority will be improved.

They were recently visited by the IG six weeks ago and are awaiting a report. Verbal recognition was given to their need.

Department Service Officer Comment: Mr. John C. Mahan

The Department Adjutant and the Department Service Officer both expressed their support for this project.

ID No. 47

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
1	Providence, RI	1	650-025	60 bed NHCU	10/82	6,500

American Legion Field Report No. 0-042

Visitation Dates: November 3-7, 1980

Space & Construction Needs: COORDINATION: A 60 bed NHCU is in the 5 Year Facility Plan scheduled for construction in FY '81. The importance of this project was portrayed throughout the survey by numerous staff. This desperately needed unit is long overdue and any delays would be very detrimental to patient care at this hospital.

SOCIAL WORK SERVICE: A shortage of beds throughout this District presents many problems and delays in referring patients to nursing homes.

CONCLUSIONS: Construction of a 60 bed NHCU is being planned for FY '81. The pressing and immediate need for this unit was expressed by numerous staff personnel. It is imperative that this project be supported by VACO and allowed to begin on schedule.

RECOMMENDATIONS: No. 3. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director insure that the planned NHCU for this facility does not encounter any delays with its construction.

Chief Medical Director's response to Recommendation No. 3.

March 9, 1981 The Nursing Home Care project is on schedule. We do not foresee any changes in our projected schedule.

ID No. 47
April 16, 1981

Assistant
VAMC Director Comment: Mr. Roland A. Dumont indicated that this(these) project is necessary because:

Rhode Island is the third highest State in the nation for older veterans and the first in number of veterans (167 per 1000). This is the only facility in RI and has a 65% SC inpatient and 75% SC outpatient work load. The affiliation commenced in 1973 and the type of care and patient work load has increased.

Space shortages in the hospital are identified in storage, teaching, and clinical areas. JCAH stated that the surgical suite is not adequate for today's modern techniques. A project is pending to correct this.

The Inspector General is currently at this facility and will be until May 21, 1982.

Department Adjutant Comment: Mr. John A. Adamowicz

He was attending activities at Newport, RI Naval Base

Department Service Officer Comment: Mr. John E. Tatro, Sr.

The Department Service Officer is not familiar with the project.

ID' No. 48

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Richmond, VA	2	651-003	Automated Transport System	5/78	4,200

American Legion Field Report No. 6-111

Visitation Dates: August 23-27, 1976

Space & Construction Needs: Fourteen projects totaling $6,755,822. have been discontinued due to construction of a new hospital.

Chief Medical Director's response to Recommendation No. None were made in reference to the above titled project.

Letters dated Nov. 9, 1976
Apr. 19, 1978
Jul. 26, 1979
Dec. 29, 1981

ID No. 48

April 15, 1982

VAMC Director Comment: Dr. James Holsinger **indicated that this(these) project is necessary because:**

In order to efficiently operate the new hospital, this project is essential in order to move supplies, medications, food, etc. to the patient areas. Two months ago, 2 members of the Inspector General's office made a study and approved the project. It was their contention that monies could be saved in other areas such as research, however, they concurred that the Automated Transport System was essential.

Department Adjutant Comment: Mr. Philip Grimm

April 15, 1982

He stated the Department of Virginia is 100% supportive of this project and feels the need is there.

Department Service Officer Comment: Mr. Robert Newsom, Asst. Director, VA Department of Veterans Affairs

April 15, 1982

Mr. Newsom has talked with the Medical Center Director at VAMC Richmond. The project in question has been discussed and Mr. Newsome supports the need for the Automated Transport System in order to provide quality care on a timely basis.

ID No. 49

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Roseburg, OR	6	653-027	OPC Addition	2/82	28,000

American Legion Field Report No. 8-047

Visitation Dates: July 17-20, 1978

Space & Construction Needs:

The hospital has been given tentative approval by VACO of $5 million for the construction of a Clinical Support Building addition. This bldg. will house the following services: Ambulatory Care, Pharmacy, Supply Processing and Distribution, Radiology, a consolidated Library and Voluntary Services. The bldg. will be a two-story structure and will have 28,000 to 30,000 square feet of floor space.

A most pressing need was identified to start construction as soon as possible on the new Clinical Support addition. This new addition when completed will considerably relieve many of the space shortages of the hospital services.

Chief Medical Director's response to Recommendation No.

Response 9/78 The new Clinical Support Building addition is a 1978 advanced planning fund project. Design and construction will be considered as future agency budget requests are developed.

ID No. 49
April 19, 1982

Assistant Director
VAMC Director Comment: Paul Scheel, 4/15/82 **indicated that this(these) project is necessary because:**

Since the Director is on vacation comments were solicited from the Asst. Director. He related that the buildings are 50 yrs. old. The proposed addition which is long overdue will affect primarily the areas of Ambulatory Care which accommodates 38,000 visits per year, Pharmacy, Radiology, Lab & MAS whose offices are inefficiently scattered throughout the 195 acres of ground. These have been cited for space deficiencies by the JCAH who visited in June '80 and who are expected again in July '82. To meet criteria in the new addition the space for lab will double, Ambulatory Care will approximately triple while Pharmacy and Radiology will almost quadruple their footage of floor space.

The Medical Center has numerous space problems and the addition will alleviate a major portion of them. However, NCHU and the psychiatric facilities present problems. NHCU has 75 beds in the main medical bldg. (Bldg. 1). It is felt that these beds should be in an independent bldg., and there is a design for '87 for 120 beds. Psychiatry in Bldg. 2 comprises half the patient population. That bldg. is under consideration in '85 for a $10 million overall renovation including air conditioning, patient privacy seismic requirements.

Department Adjutant Comment: Mr. Ron Dreeszen - 4/16/82

States he supports this project. He had no additional comments beyond the supporting statements by the Assistant Director.

Department Service Officer Comment: Mr. Glenn R. Hunsinger - 4/16/82

States they have been waiting patiently for this project and are concerned about any future delays in the project. Cites a definite need for this project in view of the age of the bldgs. and the rapid increase in population of the concerned area. Relates full Legion support for this project. States Mr. Sullivan from Central Office visited the facility.

ID No. 50

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Salem, VA	2	658-038	Renovate Bldg. 76 (Intermed)	4/77	5,510

American Legion Field Report No. 0-008

Visitation Dates: March 17-21, 1980

Space & Construction Needs:

It appears that Building 76 will be next in line in the planning process, and will be renovated for intermediate medicine beds.

Recommendation No. 1. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director provide the necessary funds to construct a new building which would centrally locate all of the fragmented medical and surgical services and support activities.

Chief Medical Director's response to Recommendation No. 1. Projects to improve facilities for outpatient, SPD and surgical services, and to renovate psychiatric bed buildings at Salem are included in the Center's Comprehensive Facility Plan. Every effort will be made to implement these projects consistent with available funding and systemwide priorities.

Letter dated June 26, 1980

In a letter dated Nov. 23, 1977 from the Administrator of Veterans Affairs, this project to renovate Bldg. 76 was approved for intermediate medicine. The modernization would include demolition of part of the existing first and second floors, construction of new partitioned, private and semi-private bedrooms with adjacent toilet and shower facilities. The building would house 80 beds divided into two 40 bed wards; one ward on the first floor and one ward on the second floor. Also included was new lighting, heating, thermal windows, new nurses call system, electric outlets, TV outlets, etc.

ID No. 50
April 16, 1982

VAMC Director Comment: Mr. Hugh Davis **indicated that this(these) project is necessary because:**

In order to provide patient care in a suitable environment as found in surrounding community hospitals, it is necessary to renovate Bldg. 76. Bathrooms must be modernized, safety features improved and better fire and safety programs implemented. The Joint Commission on Accreditation of Hospitals have previously mentioned these deficiencies, however, based on a plan to update the present facilities they have accredited the VAMC.

Department Adjutant Comment: Mr. Philip D. Grimm

The Department Adjutant expressed total support from the Department of Virginia American Legion. They definitely feel this project is essential in order to permit the delivery of good health care.

Department Service Officer Comment: Mr. Robert Newsom, Asst. Director, VA Dept. of Veterans Affairs

Mr. Newsom is well aware of the need to modernize Bldg. 76 at Salem. All members of the staff in their office support the project at the VA Medical Center, Salem, Virginia.

ID No. 51

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
San Antonio, TX	5	658-038	Supply Warehouse and S.P.D.	6/79	5,800

American Legion Field Report No. 1-025

Visitation Dates: June 1-5, 1982

Space & Construction Needs: The need was stressed for additional space for a warehouse. This was planned for Fiscal Year 1985, along with a 120 bed Nursing Home Care Unit and space for S.P.D.

RECOMMENDATION No. 2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director continue to support construction of a warehouse with additional floors to expand space for Administration and Outpatient Service.

Chief Medical Director's response to Recommendation No. 2. In a letter dated December 7, 1981 signed by the Chief Medical Director, stated: A project for building a supply warehouse is scheduled for construction in Fiscal Year 1984. Construction of a supply warehouse will make space available for other services. Funding for this project is contingent upon the availability of resources.

ID No. 51
April 16, 1982

VAMC Director Comment: Jose Coronado 4/15/82 indicated that this(these) project is necessary because:

Currently, the warehouse space is so short that when additional supplies are received there is no space to place them. It is now necessary to lease 20,000 sq. ft. of space in a building located 8 to 10 miles from the Medical Center. It is almost impossible to keep inventory straight. This requires personnel making several trips per day to move supplies to and from the Medical Center. This in turn creates problems with GSA by requiring excess mileage to be placed on GSA cars.

Department Adjutant Comment: Mr. W. H. McGregor

Mr. McGregor was not aware of the need for a warehouse but stated The American Legion would support the project, based on the Field Representatives recommendation for it.

Department Service Officer Comment: Mr. Michael Mendosa, Representative of the Texas Veterans Affairs Commission was not aware of the need for this project. He did state that a county wide Service Officers meeting is scheduled on April 28, 1982 and at that time the Medical Center Director will discuss plans for needed projects at the VA Medical Center. Mr. Mendosa stated he was sure they would support this project.

ID No. 52

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
San Francisco, CA	6	662-043	120 bed NHCU & Parking	6/82	14,400

American Legion Field Report No. 8-042

Visitation Dates: June 19-23, 1978

Space & Construction Needs:

Pending construction projects include the following:

1981 - Construction is planned for a Multi-Story Parking Structure

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Chief Medical Director's response to Recommendation No.

No response from Chief Medical Director in regard to this project.

ID No. 52
April 16, 1982

VAMC Director Comment: Dr. Foye 4/14/82 **indicated that this(these) project is necessary because:**

Medical District 27 has very few Nursing Home Care Unit (NHCU) beds i.e. 292 out of a Central Office estimated need of 680. VAMC San Francisco at present has none. There is full management & professional staff as well as community support for this project which is now approximately $1.4 million for 120 NHCU beds and $5 million for an adjacent parking structure. The project was originally budgeted for '81 & delayed yearly to '84. Outplacing patients in need of NHC is difficult because there is a shortage of skilled nursing beds, there is a high community occupandy rate (95%), and there is difficulty meeting area costs even with a special rate of $65/day. The veteran population is 50% local i.e. San Francisco City while the remaining veterans are from surrounding Bay Area Counties. Of a recent local group placed, 17 out of 23 veterans were placed 46-105 miles away. The need for the parking structure should be noted. Construction of the NHCU will knock out 90 existing parking spaces of an already congested area while adding the impact of additional staff and visitors. There is a major construction project on line for FY '83 which will address 1/3 of the space problems of the VAMC. JCAH didn't address existing deficiencies related to the areas affected by the project because of the existing plans. The Inspector General finished a 7 week visit on March 19, 1982. They did not leave a report but stated a recommendation would be made to Central Office to consider putting the NHCU on existing space. The Director is emphatically opposed to this. Three possible areas were mentioned:

(1) Bldg. 12 currently used for research. The Director described this as impossible i.e. involving huge amounts of dollars and producing only 30 beds.

(2) Bldg. 2 - a 50 year old building which is narrow with poor access & egress. The VAMC already plans to fill this building

(3) Convert regular beds - There are 357 beds and they are needed for the acute care mission. The hospital operates at 80% occupancy, with a 10 day average length of stay. The patient volume is large with a rapid turnaround rate. The Director estimates that only 15 beds could feasibly be converted to NHCU.

Department Adjutant Comment: Mr. Donald J. Michalske 4/14/82

Related he had met with Mr. Sullivan, Associate Deputy Administrator for Logistics from Central Office. Stated he wanted to emphasize the needs created by the aging population in California which is growing by leaps and bounds. Extends his strong support for this project. Had no other comments beyond those supporting statements in the Visitation Report and the Director's comments.

Department Service Officer Comment: Mr. Al Krank 4/15/82

Stated he lends his support to this project. Met briefly with Dr. West from Central Office on Monday 4/12/82. Feels the large veteran population in California will be a significant factor in having the scheduled construction implemented.

ID No. 53

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Sioux Falls, SD	5	438-020	Clinical & Support Service	10/82	21,000

American Legion Field Report No. 9-059

Visitation Dates: December 3-7, 1979

Space & Construction Needs: Because of the ever increasing presence of the Medical School affiliation the Medical Center is experiencing a steadily increasing amount of outpatients. This new increase is aggravating a poorly designed and overcrowded Ambulatory/Outpatient Care area. Expansion is needed and is mentioned in the Five Year Facility Plan. Construction for the clinical addition (earmarked for FY '83) will include improvements and expansion for the Ambulatory/Outpatient Care area, new emergency room, Laboratory, Pharmacy and Administrative functions. Funding for this new facility is urgently needed for the Medical Center's mission success in the decade to come.

ADMISSIONS, OUTPATIENT CLINIC AND AMBULATORY CARE SERVICE:

A totally inadequate and reprehensible situation exists in the Ambulatory/Outpatient Care area. The problem is space. Illustrative of this inadequacy is the frequency of patients being examined in bathrooms because of the insufficient number of examining rooms. Waiting areas are not large enough to accommodate the considerable number of patients, many of whom are walk-ins. The Ambulatory/Outpatient Care area was identified as being 5,688 square feet short of space. Because of the lack of space and the poor design of this area, an emergency room is wanting, with an ambulance entrance directly leading into it. At present, the ambulance room is located in the basement, with the emergency room one floor above. The Chief of Ambulatory/Outpatient Care maintains that this area has reached its maximum usefulness and expansion is needed.

RECOMMENDATION No. 1. It is recommended to the Administrator of Veterans Affairs and the Chief Medical Director that the medical facility improvement as outlined in the Five Year Facility Plan be expedited. The medical facility improvement would most benefit the Ambulatory/Outpatient Care area, which is seriously deficient in space.

Chief Medical Director's response to Recommendation No. 1.

"The need for additional space at Sioux Falls is recognized by Central Office. Every effort will be made to program necessary construction to the extent resources are available, and within the priorities determined by the VA medical care system."

ID No. 53
April 20, 1982

VAMC Director Comment: Mr. Dexter Dix **indicated that this(these) project is necessary because:**

of the problems it will address. The affiliation with South Dakota has generated an increased work load. The Director is optimistic that the revalidation process will only confirm the urgent need for this project. The IG team that was there in August recommended that this project be cancelled, but did not say so in the report the Director received.

Department Adjutant Comment: Mr. Maynard Hemp

Away on District meetings until Monday.

Department Service Officer Comment: Mr. Ray Asmussen

Mr. Asmussen related that this project is definitely needed. "It's a sorry mess out there." It is not a matter of maybe needing this project - it is definitely needed.

ID No. 54

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MED. DIST.	MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
2	Syracuse, NY	1	670-016	F&S Improv, Patient Privacy, & Support System	5/81	12,000

American Legion Field Report No. 0-038

Visitation Dates: October 6-10, 1980

Space & Construction Needs:

MEDICAL ADMINISTRATION SERVICE: Due to crowded conditions in the Admitting area, veterans are not afforded privacy when counseled by clerks in filling out administrative forms. Space for the details clerk is very inadequate.

------ These space problems are not related to the above project, but they were mentioned to identify space problems and in progress project should rectify the deficiencies -------

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Chief Medical Director's response to Recommendation No.

The Chief Medical Director's response to the Field Report did not respond to this future project.

ID No. 54
April 20, 1982

VAMC Director Comment: **indicated that this(these) project is necessary because:**

It deals with the elimination of the fire and safety deficiencies and patient privacy. They are going ahead with this project. Originally 40 beds were to be lost, but VACO decided on one of two plans for the support systems in the project and an additional 24 beds will be lost. The Director feels that the loss of these 64 beds will not affect the number of patients they have been treating. He did not know if these beds would be redistributed in the District.

Among the JCAH comments were recommendations dealing with the above project.

Critical space problems are currently being addressed by adding 3000 additional feet to the Ambulatory care area.

Department Adjutant Comment: Mr. Leonard E. Baxter

He sees no reason why any fire and safety project should be held up.

Department Service Officer Comment: Mr. Douglas Wheat

He is not familiar with the project, but considering the nature of it, he has no objections to it.

ID No. 55

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Tomah, WI	4	676-031	Modernize Bldgs. 406 & 408	9/82	5,400

American Legion Field Report No. 0-045

Visitation Dates: December 1-5, 1980

Space & Construction Needs:

Overall space is at a premium at this facility. Sufficient space is not available for functions like group therapy, clinics, and recreation activities. The condition of these buildings (406 & 408) is crowded and has many dead-end corridors. These buildings are partially sprinklered. Within the locked wards, inadequate space and poor ventilation are major concerns as well.

Chief Medical Director's response to Recommendation No.

No recommendation in regard to this Project.

ID No. 55
April 14, 1982

Assistant
VAMC Director Comment: Mr. Charles Ellard **indicated that this(these) project is necessary because:**

The Director was away on a training assignment for two weeks so discussions with the Assistant Director were generated.

Both these buildings were built in the early '40s. Both are extremely lacking in patient privacy. These buildings house approximately 150 patients, some in locked wards. After the renovations, 100 beds will remain. Fire and safety deficiencies are abundant, but have not been cited by JCAH. The matter of the lack of patient privacy has, however - (March 1981). This project will also correct those shortcomings associated with the lack of ventilation in these buildings. The IG made no comments pertaining to this project. A 300,000 dollar project, for this Fiscal Year, is pending in VACO to upgrade the Fire Alarm System. This reports the fire, but does not address the elimination of fire hazards. The IG visit was in July 1981.

April 14, 1982
Department Adjutant Comment: Mr. Rick Barnett

Could not add anything to what the Department Service Officer stated below.

April 14, 1982
Department Service Officer Comment: Mr. Frederick Heinle

One important aspect of this Project will be the establishment of a multipurpose room. Currently, the only available space for large gatherings is the dining room. Mr. Heinle stressed the patient privacy and fire and safety deficiencies as well.

ID No. 56

PROJECTS FOR REVALIDATION - MAJOR FY 1984

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000)
Waco, TX	5	685-041	Construction of New Dietetic Building	3/81	8,400

American Legion Field Report No. 8-068

Visitation Dates: November 13-17, 1978

Space & Construction Needs:

Plans have been submitted for a new Dietetic Building. If approved, this will be located near the Ball Park. Space will not be as plentiful but should be ample.

Most pressing need: A new Dietetic Building

Chief Medical Director's response to Recommendation No.

Letter from Chief Medical Director dated December 26, 1978.

A new Dietetic Building is included in this Center's long-range plans and is now in the planning phase. We will consider design/construction in a future budget year as our systemwide needs and resources permit.

ID No. 56

April 16, 1982

Assistant
VAMC Director Comment: Mr. Melvin Baker **indicated that this(these) project is necessary because:**

The present Dietetic Building was constructed during late 1930. In order for patients using wheelchairs to gain access to the dining room, they must be brought up to the 2nd floor by way of the loading dock. They then must come through part of the food preparation area to reach the dining room. With the construction of a Dietetic Building, a shortage of office space will still exist. The present building will still have to be used to provide office space for Dietitians. Plans call for demolition for a part of the current building. Patients will be able to enter a dining room on the first floor.

Department Adjutant Comment: Mr. W. H. McGregor

Mr. McGregor stated he was sure the project is needed, even though he has not been kept up-to-date. He stated they would give full support to the project as it appears needed.

Department Service Officer Comment: Mr. Michael Palmquist

The Department Service Officer is out of the office until April 19, 1982. I attempted to contact Mr. Walter Sawyer, VAC Representative at the VA Medical Center and he, too, was out of the office until next week.

THREE QUESTIONABLE PROJECTS

1. (ID#16) VAMC Cleveland, Wade Park Division. $15 million relocation of surgical suite from basement to put it closer to surgical floor, allowing critically needed space for expansion of laboratory and radiology service.

Legion Field Service visited site October 20-30, 1980, and identified need for more space. Report urged VA central office to fund additional clinical and parking facilities. Chief Medical Director of VA responded Feb. 2, 1981, that these recommendations plus installation of an adequate telephone system were included in central planning and "will receive due consideration as funds become available within the priorities determined for our total medical care system." Five-Year Medical Facility Construction Plan submitted to Congress on June 30, 1981, said $1.5 million would be sought in FY82 budget for design and $13.5 million in FY83 budget for construction of clinical improvements. Design funds striken from FY82 budget, no construction funds asked in FY83 budget request. Hospital Director Richard Droske told The American Legion on April 19, 1982, there remains "a critical need for additional space" and addition of parking facilities has been dropped from plan.

But Droske said the hospital currently has 10 operating rooms and will need a minimum of seven after the proposed relocation. If project results in fewer than seven operating rooms, he'd rather let it slide.

Legion Department Service Officer Robert Gainer agrees on need for space but thinks $15 million could be better used some other way "because of the present configuration of the physical plant." Gainer also is concerned construction work would disrupt the treatment of patients already being cared for.

2. (ID#22) $11 million construction of new warehouse and service building for VAMC Hines in Chicago. This project was originally requested in 1970 when it would have cost $600,000 and was finally to have been built this year (FY82) at 18 times the cost. The project was deferred after a visit to VAMC Hines by the I.G., who objected to the warehouse size and the inclusion of two bowling lanes. VAMC's current warehouse space is on Loyala University property. I.G. suggests GSA find a building for VAMC Hines to rent, instead of constructing a new warehouse.

VAMC Director John Fears told the Legion 4-16-82 he didn't like this idea because the costs of renting are "astronomical." He said VAMC Hines needs about 37,500 square feet, which would cost about $243,750 in annual rent. Director Fears also stressed the importance of having the warehouse on-station and said any adequate rental building would probably be far from the hospital.

The need for a near and accessible warehouse is clear, and what may be available is unknown to us. But the "astronomical" cost of renting is questionable when compared to the construction project cost: at a quarter million dollars per year, VAMC Hines could probably get a 40- or 45-year lease for the $11 million this project would cost. Without opposing the project outright, the Legion might concede that it needs further investigation..

3. (ID#34) VAMC Martinez, California. $14.4 million, 120-bed nursing home unit was supposed to be built in FY83 but no funding sought in administration's FY83 budget request.

Legion Field Service visited site July 20-24, 1981. It reported lack of adequate space at this facility but said growth to meet patient-care demand would be almost impossible under current constraints, and made no recommendation.

VAMC Director Nixon told the Legion this April 15 the proposal to build the nursing care unit at Martinez originated at VA central office, not locally. He thinks it would be better to put the facility at Livermore VAMC. Land for construction is a problem at Martinez which has many more medical programs following affiliation with a medical school than it was built to handle. The director is much more worried about a $25-30 million major addition and renovation project it hopes for in FY84. Space is now so cramped that administrative offices are scattered in trailers around the hospital. Local land costs is a big issue. Nixon does not dispute need for nursing home care beds to serve California's huge and aging veteran population but says VAMC Martinez has no room for the planned facility.

Legion Department Adjutant is aware of the land problem at Martinez and says owner of contiguous land jacked up the price several months ago after inquiry from VA administrator.

DSO Al Krank supports VA central office on need for nursing home facility at Martinez. Central Office is especially concerned with population projections of aging vets in area and high cost of community nursing home placements.

The questions about this construction project are not if or why, but where and how...

PHASE II
MAJOR CONSTRUCTION
PROJECTS FOR REVALIDATION

Medical District	MEDICAL CENTER	ID NO.	MEDICAL REGION	PROJECT ID	PROJECT TITLE	P.P. COMP	COST $(000
14	Allen Park, MI	57	4	101-A06	Replacement Hospital	-	220,000 Million
9	Augusta, CA	58	3	509-A69	Replacement Hospital	-	150,000 Million
3	Bronx, NY	59	1	526-080	120 Bed NHCU	-	11,000 Million
3	Brooklyn, NY	60	1	UNK.	Ambulatory Care Expansion	-	-
24	Denver, CO	61	5	554-019/ 024	Clinical Addition	=	64,000 Million
18	Fargo, ND	62	5	437-039	Clinical Addition	-	21,000 Million
6	Fort Howard, MD	63	6	566-035	Clinical Addition	-	26,400 Million
6	Fort Howard, MD	64	6	566/029	Multi Purpose Bldg.	-	1,983 Million
20	Houston, TX	65	5	580-C30	Replacement Hospital	-	400,000 Million
7	Huntington, WV	66	2	581-044	Clinical Improvement Phase II	88	15,000 Million
7	Huntington, WV	67	2	581-053	Research Addition	90	4,300 Million
26	Long Beach, CA	68	6	600-0057	New Spinal Cord Unit	-	40,000 Million

PHASE II
MAJOR CONSTRUCTION
PROJECTS FOR REVALIDATION

MEDICAL DISTRICT	MEDICAL CENTER	ID NO.	MEDICAL REGION	PROJECT TITLE	P.P. COMP	COST $(000)
20	Memphis, TN	69	3	New Construction	—	27,000 Million
11	Murfreesboro, TN	70	3	120 Bed NHCU	87	12,000 Million
3	New York, NY	71	1	Clinical Addition	88-89	102,000 Million
4	Philadelphia, PA	72	2	Clinical Addition	—	200,000 Million
25	Phoenix, AZ	73	6	Medical Building	—	15,000 Million
28	Roseburg, OR	74	6	Renovate Building 2	—	10,000 Million
28	Roseburg, OR	75	6	NHCU 120 Bed	—	11,000 Million
7	Salem, OR	76	2	Clinical Addition	—	16,000 Million
12	Tampa, FL	77	3	SCI Addition	—	6,900 Million
20	Temple, TX	78	5	Renovation of Domiciliary	—	60,800 Million
25	Tucson, AZ	79	6	Clinical Addition	85	11-12,000 Million
28	White City, OR	80	6	120 Bed NHCU	86	10,000 Million

I.D. No. 57

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1987

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	Bed **Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
Allen Park, MI	14	4	101-A06	Replacement Hospital		$220,000 million	539 VAMC 72 NHC	539	415	80 90

American Legion Field Report No. 9-021

Visitation Dates: May 21-25, 1979

Space Needs: NOT NOTED IN REPORT.

Construction Needs:

VAMC Director Comment: Mr./~~Dr~~. JAMES STEVENS, DIRECTOR indicated that this project is necessary because: the facility is obselete.

There are several space deficiencies creating poor patient accommodations. The pharmacy, for example, does not have a waiting area and all prescriptions must be sent down to admitting Via a dumb waiter. Presently, there is a contract to study wheter or not the needs of the facility can be met through moderinization or replacement. Neither is presently programmed to begin.

* Write Project Title here: REPLACEMENT HOSPITAL

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 58

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1987

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
usta, GA	9	3	509-A69	Replacement Hospital		$150,000 Million	VAMC-751 NHCU- 40	660	529	90%

American Legion Field Report No. 0-006

Visitation Dates: February25 - March 7, 1980

Space Needs: (Intermediate Medicine) there is an immediate need for an acute medicine/emergency ward.

Construction Needs: The present buildings are over 50 years old. New living quarters are needed for the psychiatric patients at this facility. (Bed Services)

It was recommended that funding be made available to construct a 200 bed psychiatry building. The construction of the building was approved as a FY 81 Advanced Planning Fund Project and was to be coordinated with the Master Plan. (Recommendations, Chief Medical Director_

VAMC Director Comment: Mr./XX. EUGENE SPEER, JR., indicated that this project is necessary because: The Director feels that, due to age and design, the present facility is not economically feasible from a staffing viewpoint. Of the present 13 two-floor buildings over half have open space on the second floor making it difficult to oversee from the nurses station. He also expressed that modernizing the facility would also create a staffing problem by reducing the wards from 31 beds to 17 beds. The Replacement Hospital would consist of four 4-floor buildings, five 2-floor buildings, and one 1-floor 120 bed nursing home. Three different contracts have been developed for the VA. The general consensus of the A/E is that it would cost less to replace the hospital than to modernize it.

*Write Project here: REPLACEMENT HOSPITAL

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 59 MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1982

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	Bed **Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
VAMC Bronx	3	1	526-080			$11,700 Million	702	655	533	81.7

American Legion Field Report No. 2-027

Visitation Dates: June 28 - July 2, 1982

Space Needs: Not in report

Construction Needs: VACO should scrutinize the design and construction of the project which is being done by the same architectural engineer who designed the hospital.

VAMC Director Comment: XXX/Dr. Julius Wolf indicated that this project is necessary because:

This project is the result of several studies performed by VACO which indicated the urgent need for this facility.

Write Project Title here: 120 Bed Nursing Home Care

Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 60

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1985

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
rooklyn, NY	3	1	unk	Ambulatory Care Expansion Project	unk	unk	VAMC-889 Brooklyn	807	783	85%

American Legion Field Report No. 0-049

Visitation Dates: 12/8-12, 1982

Space Needs: Outpatient Clinic is one of the busiest in the VA systems. A sharp increase in visits is expected over the next few years due to the advancing age of the WWII veterans. (Admission, Outpatient Clinic, and Ambulatory Care Service)

Construction Needs: "The demands on the Admission, Ambulatory Care and Outpatient Clinic have far surpassed their resourses." A proposal for an Ambulatory Care expansion project is listed in the 5 year facility plan and is slated to begin in FY 84 but will be determined by system priorities.

VAMC Director Comment: Mr./XX CHARLES GREEN, AHD indicated that this project is necessary because: there is not sufficient space to handle the 198,000 ambulatory visits each year. This lack of space causes a great deal of congestion. A Mental Health Care Program would be developed with the completion of this project. Patients must now go to the Ryuson Street Clinic at this time. Accoring to the Assistant Director, there is a reluctance on the part of the patients to go there due to a lack of available parking and the general location of the clinic. A/E has been withdrawn and it is not known if it will be renewed. The Assistnat Director did not know the cost or the Project ID number because he has not received a Data package.

*Write Project here: AMBULATORY CARE EXPANSION PROJECT

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 61

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1983

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
nver, CO	24	5	554-019/ 024	Clinical Addition		$64,000 million	VAMC-476 NHCU-N/A Dom.-N/A	344	273	81

American Legion Field Report No. 9-037

Visitation Dates: June 25-29, 1979

Space Needs/Observation: A new clinical wing was projected to cost 2 million dollars with a completion date of FY 84. It will house admission, outpatient and ambulatory care, emergency room facilities, waiting and examining rooms.

Construction Needs:

VAMC Director Comment: Mr./XXX. CARLTON SMITH indicated that this project is necessary because: of cramp and crowded conditions. VAMC is a tertiary referral for the surrounding states. It is responsible for all specialized surgery but the operating rooms have not been updated in 30 years. There has been no expansion or renovation of the entire hospital since it was built in 1951. Six floors are to be built on the North Wing of the hospital. The project is due to go to bid in September or October of 1982.

*Write Project here: CLINICAL SUPPORT WING A/C, SAFETY AND FIRE DEFICIENCIES

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 62

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1983

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
Fargo, ND	18	5	437-039	Clinical Addition		$21,000 million	VAMC-210 NH- 50	210	155	69

American Legion Field Report No. 9-058

Visitation Dates: November 27-30, 1979

Space Needs/Observations: "However, the most pressing need is the clinical addition which is earmarked for construction in FY 83. This construction project, as outlined in the five year facility plan, would significantly alleviate the overcrowding now being experienced in the Ambulatory/Outpatient Care Area. The new addition would also provide expansion and new facilities for surgery, supply, and intensive care units. Because the outpatient caseload has doubled over the past year, this alone would warrant the construction of the clinical addition".

Construction Needs: (ADMISSIONS, OUTPATIENT CLINIC AND AMBULATORY CARE SERVICE)

"The most pressing problem however, is the inadequate amount of waiting area space and insufficient number of examining rooms"

Recommendations: 1. In light of the serious crowding in the Ambulatory/Outpatient Care area and the increased ambulatory visits, it is recommended to the Administrator of Veterans Affairs that construction of the clinical addition be expedited. Response from Chief Medical Director 5/5/80: "Construction of a clinical addition for the Ambulatory/Outpatient Care area at Fargo will proceed as expeditiously as possible within the constraints of available resources and nationwide priorities".

VAMC Director Comment: Mr./MR. FRANCIS GATHAM indicated that this project is necessary because: of crowded conditions. This hospital is a training facility for third year medical students. There is a lack of education space as well as office space. This addition will contain 5 floors consisting of 42,874 square feet. The project has been approved for construction and will go out for bid in September 1984.

*Write Project here: CLINICAL ADDITION

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 63

PRIORITY II

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1987 & Future

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	Bed **Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
566 Fort Howard MD	#6	Mid-Atlantic Region	566-035	See below		26,400 Million	223 Hosp. 47 NHCU	223 Hosp. 47 NHCU	198 Hosp. 44 NHCU	86% Hosp. 96% NHCU

American Legion Field Report No. 2-019

Visitation Dates: May 10-14, 1982

Space Needs: VAMC Fort Howard is an Extended Care Facility. The original hospital building was activated in 1943. The internal environment is functionally obsolete, congested, grossly inconvenient, unattractive, frankly unacceptable and substandard.

It was recommended that a 6th floor (including basement) be approved for construction

NEW CLINIC ADDITION (WING)

Construction Needs: 60 New Acute Care Beds to include a comprehensive ICU; RCU
100 Intermediate beds - Bldg. 225
60 NHCU beds to Bldg. 225

VAMC Director Comment: **Mr.** Robert Haith, Jr. **indicated that this project is necessary** to accommodate:

All new Clinic Spaces appropriately appointed: G.U.; Hemodialysis; Orthotic Laboratory; Prosthetics Lab; Admitting (Examining & Processing); E.O.R.; Clinical Laboratory; Radiology; Audiology/Speech Pathology; Patient Day Rooms; Patient Visitation; Examining-Treatment Rooms; ARU; Podiatry; Ophthalmology; Medical Clinics; Psychiatric; Nutritional; Doctors' Offices; Complete Patient Units of 60 beds of Acute Care; Endoscopy, etc.

*** Write Project Title here:** Construct New Wing, B#225, Design/Construct

****Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary**

I.D. No. 64

PRIORITY 1

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1985

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	Bed **Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
rt Howard (566) MD	No. 6	No. 2	029	See below		1,983 Million	223 Hosp. 47 NHCU	223 Hosp. 47 NHCU	198 Hosp. 44 NHCU	86% Hosp. 96% NHCU

American Legion Field Report No. 2-019

Visitation Dates: May 10-14, 1982

Space Needs: VAMC Fort Howard has a very painful need for more space, more functionally efficient space, with aesthetic quality. All Medical Center programs suffer from insufficient space according to VA H-08-9 Standards and other acceptable criteria.

Additionally, we have 11 Quonset Huts in use - 8 of which are in daily use for direct care to patients.

Construction Needs: Prefabricated Butler Building - 25,000 NSF, between and connecting Buildings 225 and 61 It was recommended that the construction of the Multi-Purpose Building be approved.

VAMC Director Comment: **Mr.XDX** Robert Haith, Jr. **indicated that this project is necessary because:**

The most immediate solution to the primary space problem is to construct a Pre-Fab Butler Building of 25,000 NSF to accommodate the functions presently in the 8 quonset huts. The quonsets are in dire need of repair and to do so is uneconomical. Too, we need a bridge between Building 225 and Building 61 which will enable us to make greater use of Building 61 for operating purposes.

*** Write Project Title here:** Construct Multi Purpose Building

****Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary**

I.D. NO. 05
5

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1985

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
ouston, TX	20	5	580-C30	Replacement Hospital		$400,000 million	NH 78 VAMC-1060	VAMC-1030	858	85

American Legion Field Report No. 1-045

Visitation Dates: September 28-October 2, 1982

Space Needs/Coordination: At the Medical Center my first meeting was held with the Medical Center Director. I learned at this meeting that among some of the major needs was the replacement of the present facilities with a new facility, wherein many treatment units could be consolidated, thus making it more convenient to serve veterans on a timely basis and, also, eliminating the staff from being so widely scattered. With the many buildings which are identified as "finger wards", you find open bay areas with little privacy among patients. The bath and shower facilities are old and even though kept as clean as possible, are not the most attractive.

Conclusion: My concern centered around the age of some of the buildings described as finger wards, which have already been in constant use, 30 years beyond their planned expectancy. It is hard to maintain these buildings to meet the demands of modern day medicine. Bathroom facilities are difficult to retain and plumbing problems are numerous. Treatment areas are widespread which makes employee supervision difficult. An interim plan has been proposed to replace the Spinal Cord Injury service as well as constructing an Ambulatory Health Care Clinic. These would perhaps benefit the facility to some degree. It does appear that a total new replacement plant would be a wiser expenditure if funds can be procured.

CON'T

VAMC Director Comment: Mr./~~Ms~~. JOHN SHEEHAN indicated that this project is necessary because: facility handles acute patients. There are no single rooms; just large wards. This is not condusive to good morale since most of the patients are terminally ill. The ventilating system does not circulate fresh air making it difficult to control infection. According to the Director, the bath and toilet facilities are in "sad shape". The request for a replacement hospital was first made in 1978. A full replacement is estimated at $400million and a partial replacement at half that amount.

*Write Project here: REPLACEMENT HOSPITAL

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

(CONT)

I.D. No. 65 MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1985

VAMC: Houston, TX

American Legion Report No. 1-045

Visitation Dates: September 28-October 2, 1982

Recommendation: 1. It is recommended to the Administrator of Veterans Affairs and to the Chief Medical Director that they exert their efforts to Congress in an attempt to procure funding in the 1983 Fiscal Year budget sufficient in amount to replace the entire Medical Center at Houston, Texas. In so doing this would alleviate the need for separate funding for a Spinal Cord Injury and Ambulatory Health Care Unit, since these as well as a new 120 bed Nursing Home Care Unit could be consolidated into a total master plan to meet the upcoming needs of health care for veterans relying on that facility.

Response from Chief Medical Director 1/13/82: " The VA's Five-Year Medical Facility Construction Plan (fiscal years 1982-86), submitted to Congress in June 1981, calls for replacement of the Houston VAMC. Decisions on the fiscal year 1983 budget will not be submitted to Congress. Replacement of the Houston VAMC is a high priority. However, funding for the construction is dependent on the availability of resources and system-wide medical care priorities".

I.D. No. 66

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 85

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Capacity Bed	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
581 Huntington, WV	7	2	581-044	*	FY88	$15,000 Million	180	180	153	85%

American Legion Field Report No. 2-026

Visitation Dates: June 21-25, 1982

Space Needs: There are several space deficiencies and a need to increase the number of beds in psychiatry, surgery, and intermediate care. If thoraic surgery is performed, additional space will be needed. (Observation; Professional Services)

Construction Needs: Phase II of the Clinical Addition is planned for FY 85 and would eliminate the current space problems. Thirty bed units for psychiatry, surgery, and intermediate care would be included in the project. Construction for the Clinical Addition (Phase II) is recommended for FY 85.

VAMC Director Comment: Mr./~~Dr~~. A. PAUL KIDD indicated that this project is necessary because:

This addition is necessary to correct gross space deficiencies in Surgery, Medicine and Radiology as well as increase our bed capacity to meet the projected facility needs.

* Write Project Title here: Clinical Improvement Addition Phase II

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

Form prepared 6-24-82. Due to construction our average year to date operating bed capacity is 123 with an ADC of 110.

I.D. No. 67

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 88

/ Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
581 Huntington, WV	7	2	581-053	*	FY90	$4,300 Million	180	180	153	85%

American Legion Field Report No. 2-026

Visitation Dates: June 21-25, 1982

Space Needs: The present 10,000 square foot building does not provide adequate lab and office space. Additional space is also required for equipment and a conference room. (Research)

Construction Needs: Construction for 15,000 square feet proposed for FY 88 would correct the present space deficiency. A recommendation for this project was not made with this request.

VAMC Director Comment: Mr./Dr. A. PAUL KIDD indicated that this project is necessary because:

Current space allocated to Research Service is fully occupied. Threfore, we have no space for expansion or to support new staff physicians who receive VA research funds to conduct research investigations. With the construction planned for FY 1988 and completion probably not until FY 1990, this restricts the growth capability of this Medical Center and the physician recruitment in concert with the Marshall University School of Medicine.

* Write Project Title here: Research Addition - Building 5

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

Form prepared 6-24-82. Due to construction our average year to date operating bed capacity is 123 with an ADC of 110.

I.D. No. 68

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1985

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average **Oper Beds	Average Daily **Census	Bed OCC **Rate
ong Beach California	26	6	600-0057	New Spinal Cord Unit		$40,000 million	VAMC-1580 NH- 180	854	901	74

American Legion Field Report No. 1-016

Visitation Dates: March 16-20, 1981

Space Needs:

Nothing pertaining to a new SCI Unit was reported.

Construction Needs:

VAMC Director Comment: Mr./XX. John J. Lee indicated that this project is necessary because: VAMC is the largest Spinal Cord facility in the country. There is a definite need for the 120 bed unit with a basement to house prosthetics. The patient "PODS" (wards) do not meet the primary requirements of the Joint Commission on Accreditation of Hospitals. A/E has done preliminary work, but has been held up because PVA was unhappy with the plans. It has also been held up because the Veterans Administration wants to see what impact the addition of thirty (30) beds each in San Diego, Palo Alto, and Seattle has on the West Coast. The Director believes if this is their only rationale for delaying the project, they're not being very intelligent.

*Write Project here: NEW SPINAL CORD UNIT

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 69

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 85

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average **Oper Beds	Average Daily **Census	Bed OCC **Rate
emphis, TN	20	3	614-011	New Construction		$27,000 million	VAMC-587 Dom.-528 NHCU- 96	587	427 435.9 96	70%

American Legion Field Report No. 1-023

Visitation Dates: April 27 - May 1, 1982

Space Needs: (Nothing)

Construction Needs:

VAMC Director Comment: Mr./~~DR~~. HERBERT S. ARNETT indicated that this project is necessary because: there is a shortage of space and there is a need for additional beds. The surgical suite is antiquated and needs to be modernized. Laboratory space is so limited at this time, some of the equipment had to be moved into the hallway. The Outpatient Clinic is cramped, making it difficult for the staff to give quality care. The Director has had to move four administrative services to other buildings in order to make space. This move has made it difficult to coordinate the daily workload.

*Write Project here: NEW CONSTRUCTION

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 70

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 85

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
ırfreesboro, ennessee	11	3	622-049	120 Bed NHCU	87	$12,000 Million	VAMC-722	512	450	85

American Legion Field Report No. 1-038

Visitation Dates: August 24 - 28, 1981

Space Needs: The number of beds is inadequate to meet the demand; resulting in a long waiting list.

Construction Needs: There is a need to construct an additional Nursing Home Care Unit to compliment the present 48 bed NHCU. The construction budget was approved to increase the NHCU by 72 beds.

VAMC Director Comment: Mr./MX. HOMER MONTGOMERY:AND ROBERT PEPIOT, indicated that this project is necessary because: the VAMC is a psychiatric long-term care facility. The Assistant Director believes that treatment for these patients is more appropiate in the nursing home than in the hospital. There are presently 48 beds in the nursing home care unit and this project will give a net increase of 72. A/E is at the facility now and the designs should be completed by the end of the year.

*Write Project here: 120 BED NURSING HOME CARE UNIT

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 71

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1985

Medical Center	Medical District	Medical Region	Project ID	*Project Title	P.P. Grp	Cost $(000)	**Bed Capacity	Average **Oper Beds	Average Daily **Census	Bed OCC **Rate
w York,NY	3	1	630-028	Clinical	[illegible]	$102,000 Million	VAMC-795	815	675	81%

American Legion Field Report No. 9-051
7-019

Visitation Dates: September 24-28, 1979
March 14-22, 1977

Space Needs: Chest surgery, waiting areas, Ambulatory Care and psychiatric screening lack adequate space to accommodate the increasing number of patients.

Construction Needs: The construction of the Clinical Addition would eliminate the duplication of services now being experienced at the hospital and the 7th Avenue Outpatient Clinic.

VAMC Director Comment: Mr./~~Mrs~~ JAMES DOOLEY indicated that this project is necessary because:
The Outpatient Clinic has been cited by the Joint Commission for Accredidation for a deficiency in the fire safety code. The clinic was converted from a GSA Warehouse in 1945. The Director has no control over a GSA Building. In addition, the $102million will be used to correct deficiencies in the Operating Suite, Intensive Care and Radiology. The new addition would consist of five (5) floors with approximately 205,860 square feet.

*Write Project here: CLINICAL ADDITION

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 72

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 85

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
ladelphia nsylvania	4	2	642-027	Clinical Addition		$200,000 Million	VAMC-478	365	365	82%

American Legion Field Report No. 2-009

Visitation Dates: February 25 - March 5, 1982

Space Needs: "According to the Space and Functional Deficiency Indentification System (SFDIS), VAMC Philadelphia has been identified as the third worst Medical Center in the system in regard to space and function." With the construction of the Clinical Addition, these space needs would no longer be a major problem and would improve each of the patient treatment services. (Observation and Conclusions).

Construction Needs: Constructed in 1952, this VAMC has enlarged in size due to several approved projects. However, these projects have not included nor provided additional space for patient care activities. It was recommended that the project be placed in the newly formulated comprehensive, 5 year plan. The project is to be included in the construction plan for FY 85. Relocation of the downtown Ambulatory Care Center is also being considered as part of the project (Observation; Recommendations; Chief Medical Director).

VAMC Director Comment: Mr./~~Dr.~~ BARRY BELL indicated that this project is necessary because: the facility is presently 50% short of space. The addition of 800,000 square feet will double the size of the VAMC. Tertiary care is impossible to give because of the age of the building. The addition would elliviate the crowded conditions in the waiting areas and add much needed improvements to the surgical suite, laboratory, radiology, etc.

*Write Project here: CLINICAL ADDITION

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 73

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 87

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average **Oper Beds	Average Daily **Census	Bed OCC **Rate
oenix, AZ	25	6	644-012	Medical Building	unk	$15,000 million	VAMC-470	470	340	83

American Legion Field Report No. 1-015

Visitation Dates: March 16-20, 1981

Space Needs/Observations: A new Clinical Administrative Building is presently at the design stage. This building will ultimately relieve the congestion in the outpatient area. The outpatient area was originally designed for 65,000 annual visits but is now close to 120,000 visits. Numerous times throughout the survey, this area was observed as being congested and often in a state of chaos due to insufficient space. This new building will provide adequate space due to the relocation of many services.

Construction Needs: (ADMISSIONS, OUTPATIENT CLINIC AND AMBULATORY CARE)
Space throughout this service is inadequate. This area was designed for 65,000 outpatient visits per year. Last year, over 111,000 were realized. Additionally, the ACOS for Ambulatory Care stated this service may reach 125,000 visits this year if they continue at their present rate. Patient waiting areas were observed to be congested and noisy throughout the survey. The time of day was a factor. It was evident that relief is needed for this ever increasing ambulatory care program. The immediate need for improved observation space was discussed with the ACOS for Ambulatory Care. This observation space is needed for certain patients awaiting laboratory results, X-rays, or admission. Oftentimes, in an effort to more closely
(CON'T)

VAMC Director Comment: Mr./DXX RAY BOURNE indicated that this project is necessary because: the addition would remove such functions as mental health and hygiene from the main hospital creating more space but would not resolve the needs of the hospital. There has been a 50% increase in application this year and there is an expected 57% growth for the city by the year 1990. A comprehensive study was requested last year, and even though Dr. Custis agrees the need is there and a study should be done, a team has not been sent to the hospital. It is unknown at this time if the Indian School next door is going to close. A request for 5 acres of land adjacent to the VAMC was denied by the Department of the Interior.

*Write Project here: MEDICAL BUILDING

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

(OVER)

I.D. No. 73

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1987

Phoenix, AZ

American Legion Field Report No. 1-015

Visitation Dates: March 16-20, 1981

(CON'T)

observe these patients, they are left in the hallways.

Conclusions: The space problems associated with the outpatient area are being addressed with a proposal for a new Clinical Administrative Building. Medical Center management reported that this building is presently in the design stage. Numerous personnel and observations highlighted the immediate need for this building. The outpatient areas is encountering many space problems, oftentimes compromising patients' privacy. Despite rigorous controls, the outpatient census continues to rise at an alarming rate. This area was designed for 65,000 annual visits. At the present rate, the facility will record over 120,000 visits this year.

Recommendations: 4. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director provide funding for the planning and construction of the proposed Clinical Administrative Building.

Responce from the Chief Medical Director 9/18/81 "We concur with the need for a clinical Administratative Building as is scheduled for construction in FY 1985".

I.D. No. 74

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 85

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
653 Roseburg Oregon	28	6	029	Renovate B-2		10,000 Million	HOSP 342	342	274	80%
							NHCU 75	75	73	97%

American Legion Field Report No. 2-020

Visitation Dates: May 10-14, 1982

Space Needs/Conclusions: Building 2 needs renovation to correct fire, safety, and seismec deficiencies. This building currently houses psychiatry and intermediate care.

Recommendations: 2. The American Legion recommends the authorization for funding and renovation of Building 2 to correct fire, safety and seismec deficiencies. No response from OMD to date.

Construction Needs:

To correct seismic deficiencies and to provide patient privacy and adequate ventilation & A/C.

VAMC Director Comment: Mr./~~Dr~~. T. Kaye Miyamoto indicated that this project is necessary because:

In order to accomplish the above, it will be necessary to completely gut the structure, install seismic corrections, and arrange area to meet patient privacy with A/C & ventilation requirements.

* Write Project Title here: Renovate B-2

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

ID No. 75

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 87 & Future

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	Bed **Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
653 Roseburg Oregon	28	6	044	NHCU Bldg		11,000 million	HOSP 342	342	274	80%
							NHCU 75	75	73	97%

American Legion Field Report No. 2-020

Visitation Dates: May 10-14-1982

Space Needs/Observations In FY 88, the construction of 120 bed NHCU is planned. The project would eliminate the 75 bed NHCU located on the third floor of Buidling 1. This NHCU needs to be replaced due to is extremely crowded conditions ...[and poor location].

(CON'T)

Construction Needs:

Interior room and overcrowded service area used for Nursing Home Care was sited by JCAH 8-1-80.

VAMC Director Comment: Mr./~~Dr~~. T. Kaye Miyamoto indicated that this project is necessary because:

The present location used for the Nursing Home Care Unit is one floor, three floors up, and sandwiched between the Medical and treatment floors. A new structure, set aside from the other Medical Center activities, will also fill the need for extra beds.

* Write Project Title here: Nursing Home Care Unit Building

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

(OVER)

Roseburg, Oregon

American Legion Field Report No. 2-020

Visitation Dates: May 10-14-1982

Con't---NURSING HOME CARE UNIT If it were not for the dedicated staff at this facility, the patients assigned to this 75 bed NHCU would definitely suffer. The nursing home is located on third floor of Building 1. The space is grossly inadequate. Many beds are cramped together on reconverted porches. Mobility space is hendered by the fifty-five wheelchair patients and 10 geriatric chairs. Only three community toilets on each side of the unit are available for use by most patients. (Four private rooms have their own bathrooms.) There are only two shower rooms and one bath tub.

Conclusion The NHCU is very crowded. If it were not for the dedication of nursing home staff, these veterans would be nothing more than warehoused. A renovation project will reduce the beds by eleven. This will alleviate some of the space problems, but will not meet the needs of the aging veterans. The waiting time to get into the unit today is approximately two years. Additional beds are needed, not less. The construction of a 120 bed NHCU scheduled for 1988 is a pressing need. Any delay in its construction will be a disservice to the aging veteran.

Recommendations: 3. The American Legion recommend the funding for construction of a 210 bed NHCU as outlined in the Facility Five-Year Plan.

I.D. No. 76

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 85

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
alem, VA	7	2	658-050	Clinical Addition		$16,000 Million	VAMC-744 NH -100	744	630	85%

American Legion Field Report No. 0-00

Visitation Dates: March 17-21, 1980

Space Needs: Not in report.

Construction Needs:

VAMC Director Comment: Mr./~~MX.~~ HUGH DAVIS indicated that this project is necessary because: the clinics are spread among four or five buildings causing the veterans to become confused, irritated, and disenchanted with having to walk so far. Usually, by the time the veteran gets to his next appointment, there is a long line and a lack of waiting space. This addition would resolve these problems. The Director commented that the government could have saved 10million dollars if this, the second phase of the project, had been started when the first phase began two years ago. A/E is now working on the plans for this four-floor 99,000 square feet building.

*Write Project here: CLINICAL ADDITION

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 77

MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 19 86

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
Tampa, FL	12	3	673-016	SCI Addition		6,900 million	697	697	590	85%

American Legion Field Report No. 1-043

Visitation Dates: August 31-September 4, 1981

Space Needs: "This very busy service runs over 90% occupancy each year with a regular waiting list"

Space on this 42 bed unit is limited and many items have to be stored in the hallways or bowel care room. This problem should be eliminated when the new addition is added and this area is refurbished. The 100 bed (60 chronic, 40 acute) unit is planned for FY 86.

Construction Needs:

Recommendations: NO RECOMMENDATIONS MADE.

VAMC Director Comment: Mr./[illegible]. RICHARD SILVER indicated that this project is necessary because:

The number of paraplegic and Quadraplegic patients is increasing in the Bay area. The 42 Acute Beds are nearly at 100% occupancy. There are no chronic SCI beds at this hospital. The tentative assignment for the 100 bed is: Acute-20, Post Acute-40, Chroinc-40. This VA Hospital would become the southeastern Regional Center for SCI. advanced planning is scheduled for FY 83

*Write Project here: SCI ADDITION

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 78 MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1986

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average **Oper Beds	Average Daily **Census	Bed OCC **Rate
ple, TX	20	5	674-024	Renovation of Domiciliary		$60.8,000 million	VAMC-587 Dom. -528 NHC - 96	587	VAMC-427 Dom.-435.9 NHC- 96	70%

American Legion Field Report No. 1-001

Visitation Dates: January 19-23, 1981

Space Needs/Domicilary: Plans are being discussed to reduce the bad capacity to 375 by FY 1984. The past operating years indicated a serious need for a minimum of 400 beds. The census has gone from 390 to 546 over the past nine years and there is no indication that major changes will occur in the future. Staffing appears adequate and many improvement have and are continuing to be made in improving living quarters. All new furniture has been installed with redecorating of the rooms.

Construction Needs:

VAMC Director Comment: Mr./~~Dr.~~ EUGENE A. BURRELL indicated that this project is necessary because: the domiciliary is extremely old and unsafe. If it were to be renovated, it would have to be completely gutted. The building is not air conditioned, though, there are a few window units. A proposal for a 400 bed unit was cut by central office to 200 beds. A feasibility team has been requested to study whether or not the old building should be renovated or a new one built.

*Write Project here: RENOVATION OF DOMICILIARY

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 79 MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1983

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	**Bed Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
cson,AZ	25	6	678-048	Clinical Addition	85	$11-12,000 (million)	325	325	233	74

American Legion Field Report No. 1-057

Visitation Dates: November 30 - December 4, 1981

Space Needs: Space is limited as the original plans for the Building constructed in 1978, were designed for 3 floors of 40 thousand feet but is a 2 story building with 19 thousand square feet. The third floor is acutely needed in order to construct an entrance to the hospital.

Construction Needs/Recommendations: It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director lend support to construction of a new clinical building to house surgery, dental, radiology, and prosthetics, there by freeing up space to expand other crowded areas in many services.
Response of Chief Medical Director 3/16/82 "Construction of a new clinical building is scheduled to begin in July 1982. The new building is expected to be completed during fiscal year 1984 and renovations of the existing space are to be completed in fiscal year 1985"

VAMC Director Comment: Mr./MR. GAYLORD MORTON indicated that this project is necessary because: Project was approved last year. Bids are to open August 18, 1982 and construction is to begin in September or October of 1984. This will be a two floor building with a penthouse and an unfinished basement totalling 90,000 square feet.

*Write Project here: CLINICAL ADDITION- ADD ON CONSTRUCTION

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

I.D. No. 80 MAJOR CONSTRUCTION PROJECTS FOR REVALIDATION - FISCAL YEAR 1987 & Future

Medical Center	Medical District	Medical Region	Project ID	Project *Title	P.P. Comp	Cost $(000)	Bed **Capacity	Average Oper **Beds	Average Daily **Census	Bed OCC **Rate
VA Domiciliary White City, OR	#28	#6	692-046	Constr. 120 Bed NHCU	1986	$10,000 million	1,040	1,040	877	84%

American Legion Field Report No. 2-022

Visitation Dates: May 17-20, 1982

Space Needs: Nothing noted in report.

Construction Needs:

VAMC Director Comment: Mr./Dr. Miss Mary Ann Coffey indicated that this project is necessary because:

Ageing domiciliary patients will require higher levels of medical and nursing care than what is currently available at this domiciliary.

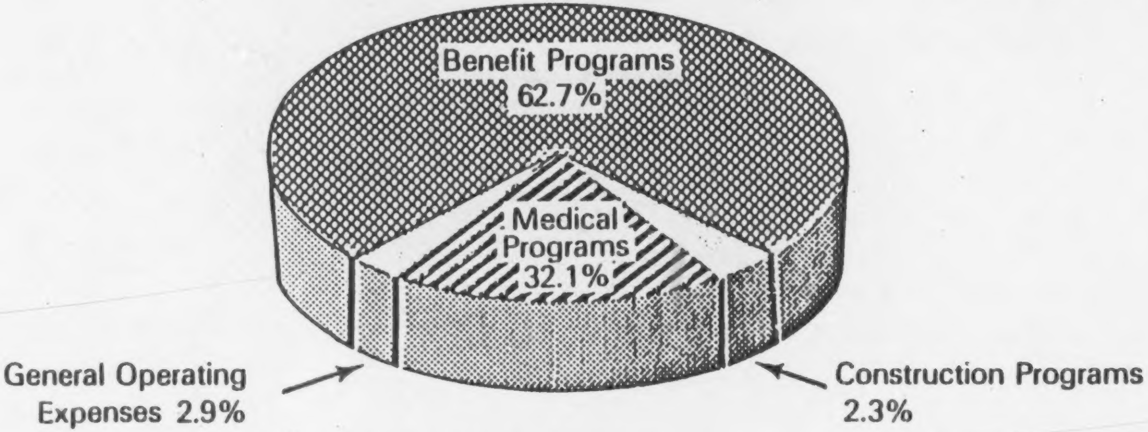
* Write Project Title here: Construct 120 Bed Nursing Home Care Unit

**Separately by category - Medical Center, Nursing Home Care Unit, Domiciliary

Veterans Administration

1983 Appropriations Request

Nov. 9, 1982
Wash. Hilton Hotel



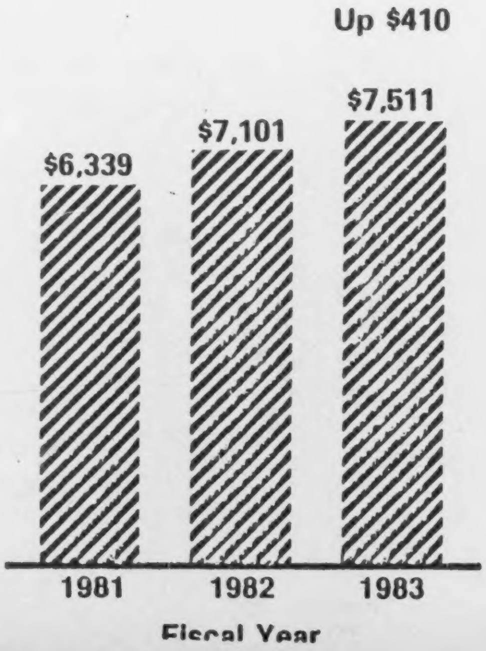
Distribution by Major Programs
(In Millions of Dollars)

General Operating Expenses	$ 689
Benefit Programs	15,105
Medical Programs	7,738
Construction Programs	549
Total, VA	$24,081

Veterans Administration

Medical Care

(Appropriations in millions)



- Average Employment Up 1,759 to 188,046

- Funding Up $410 million:

• Pay Raise and Related Increases	$111
• Inflation (5.4%) and Increased Usage	199
• Workload Increases	41
• Capital Investment	27
• All Other	32

- Provides for:
  - 3 New Nursing Home Care Units
  - Other Program Improvements
  - Activation of Facilities and Systems

MEDICAL CARE APPROPRIATION
Backup Information

Budget Authority up $410 Million, FTEE up 1,759

Analysis of Increase:	B.A. (in millions)	FTEE
Pay Raise and Related Increases:		
Pay Raise Annual	$ 3	...
Normal Salary, Wage Board, Stipend & Other	108	...
Inflation (5.4%) and Increased Usage:		
Inflation	158	...
Increased Usage	41	...
Workload Increases:		
Activations (excluding equipment)	49	1,183
Beneficiary Travel reduction 1/	- 24	...
Community Nursing (Cong. Action 10,000 ADC)	4	...
Other (App. Transfers and CALM Savings)	12	- 137
Capital Investment	27	...
All Other (Incl. 1983 Cong. Action, (Agent Orange trans. and Nursing support), Other Prog. Impr. & E&T incr.)	32	713
Total Increases	410	1,759

1/ Beneficiary travel reduction will be absorbed through savings in other areas.

Provides for:

- 3 New Nursing Home Care Units:
  - Richmond, Virginia
  - Hines, Illinois
  - Wilkes-Barre, Pa.
- Other Program Improvements (discussed later)
  - Minicomputer Applications
  - Unit Dose
  - Spinal Cord Injury
  - MEDIPP
  - GRECC-Enhancement

Veterans
Administration

Other Program Improvements

(Dollars in thousands)

	Average Employment	Obligations
Minicomputer Applications	+ 30	$+3,000
Pharmacy unit dose bed conversions	+ 100	+2,156
Spinal cord injury initiatives	+ 16	+ 820
Medical district initiated programing planning	+ 28	+ 800
Geriatric research, education and clinical center enhancements	+ 3	+ 216
Total	+ 177	$+6,992

OTHER PROGRAM IMPROVEMENTS
Backup Information

Minicomputer Applications
ADP decentralization will allow user designed systems to be implemented in VA Medical Centers.

Unit Dose
With the resources requested, as many beds as possible will be converted to the unit dose system up to 14,968 beds.

Spinal Cord Injury
Will provide contract care for 15 veterans and phase-in of Home Care Units at two SCI centers.

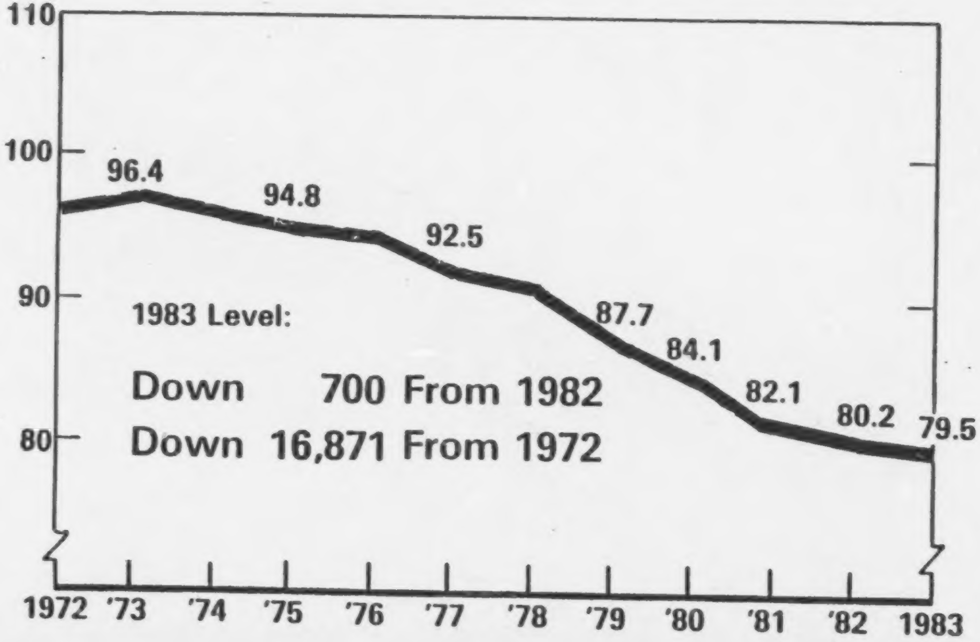
MEDIPP
Process is designed to involve administrative and clerical personnel at all levels of DM&S. The District plans which result from this process will indentify future health care delivery needs.

GRECC
These resources will provide for full staff and funding for the one understaffed GRECC of the eight existing centers.

Veterans Administration

Operating Beds - Average - VA Hospitals

(In thousands)

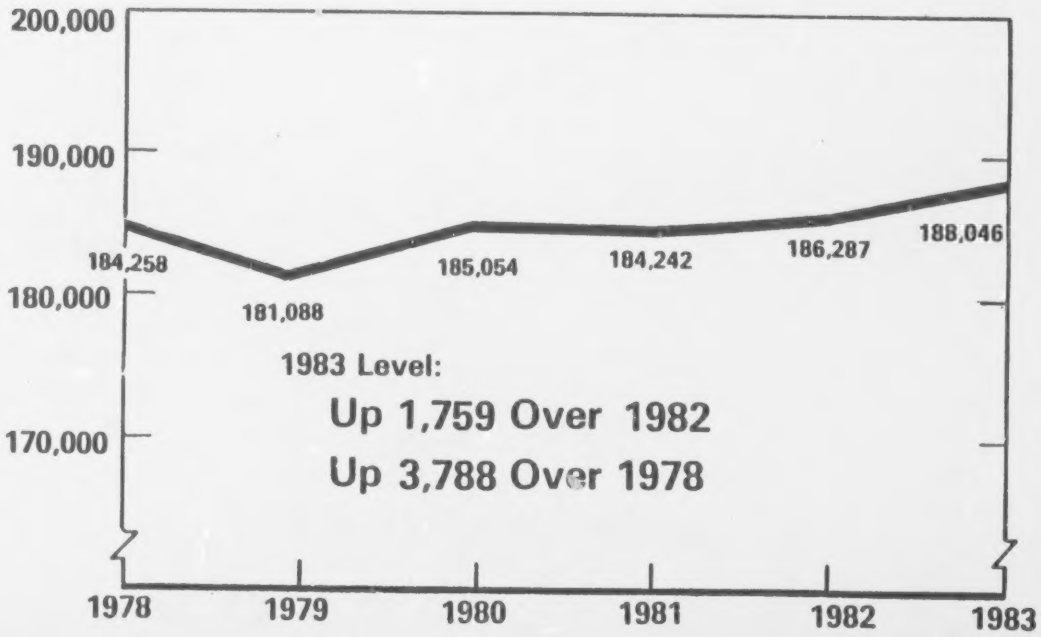


1983 Level:

Down 700 From 1982
Down 16,871 From 1972

Veterans Administration

Medical Care
Average Employment



1983 Level:

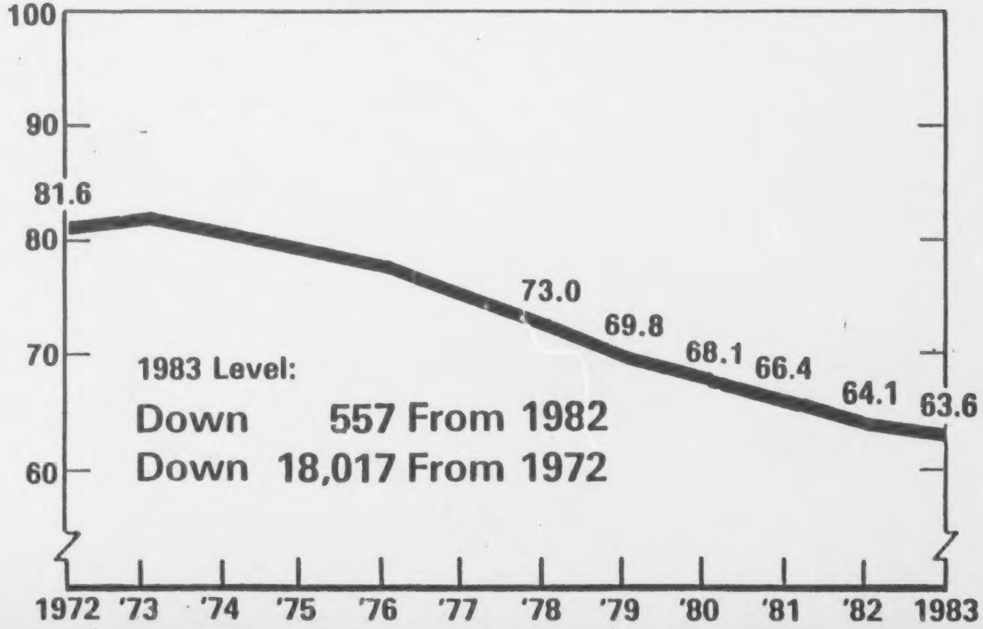
Up 1,759 Over 1982

Up 3,788 Over 1978

Veterans Administration

Average Daily Census
VA Hospitals

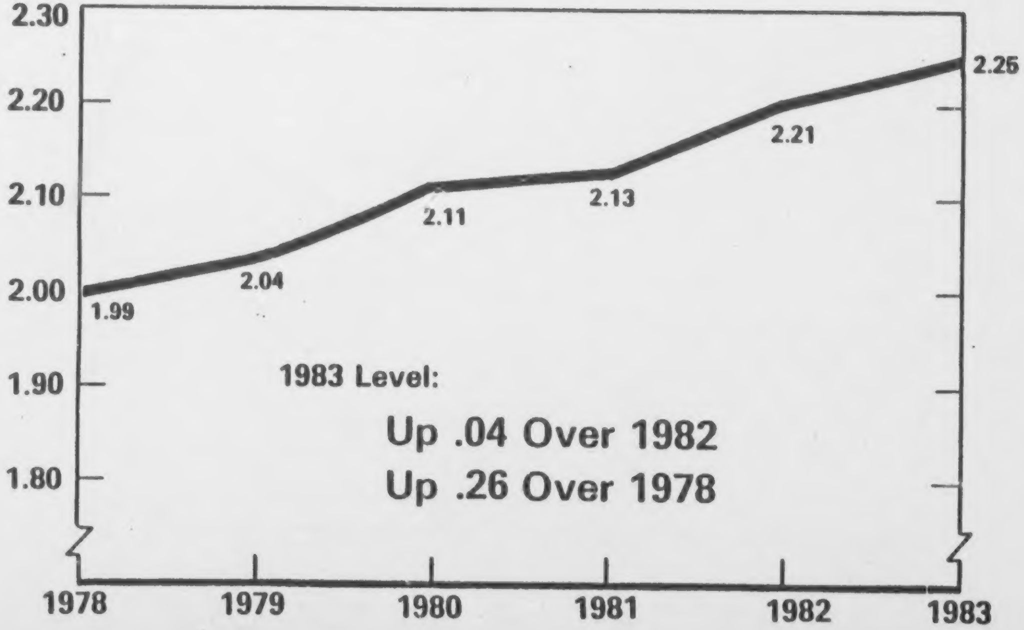
(In thousands)



Veterans
Administration

VA Hospital Staffing Ratios

Employees Per Patient Census



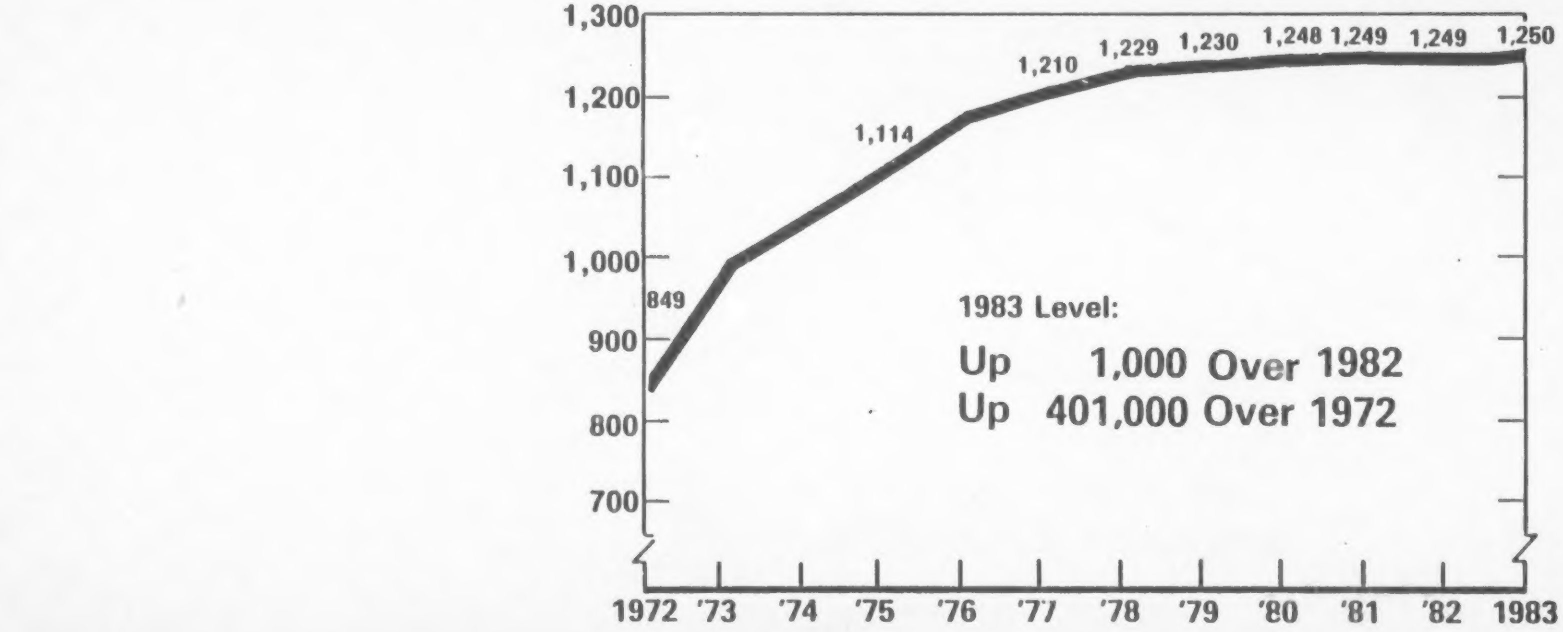
1983 Level:

Up .04 Over 1982
Up .26 Over 1978

Veterans
Administration

Inpatients Treated - VA Hospitals

(In thousands)

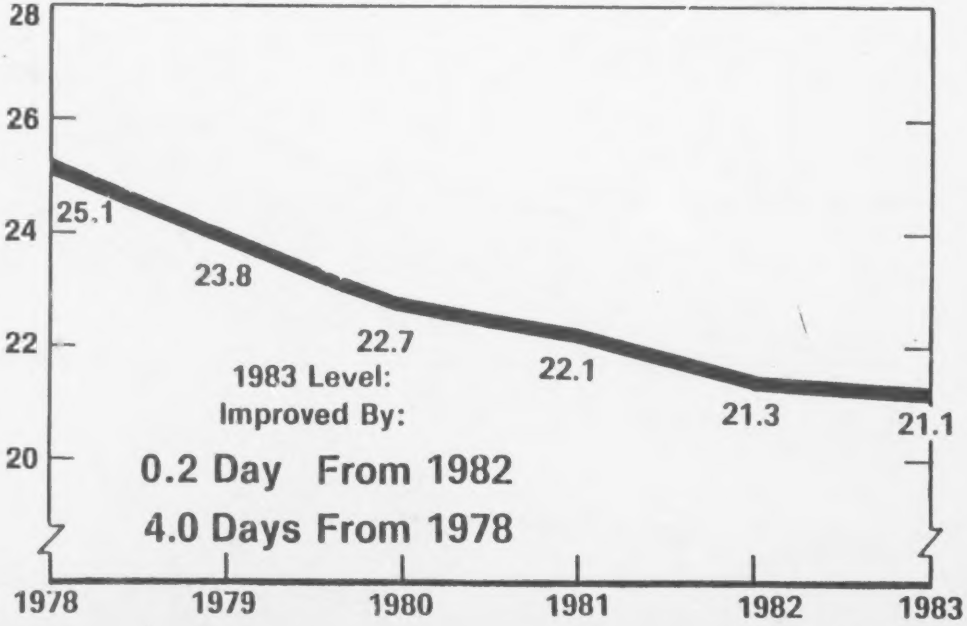


1983 Level:

Up 1,000 Over 1982
Up 401,000 Over 1972

Veterans Administration

Length of Stay - VA Hospitals

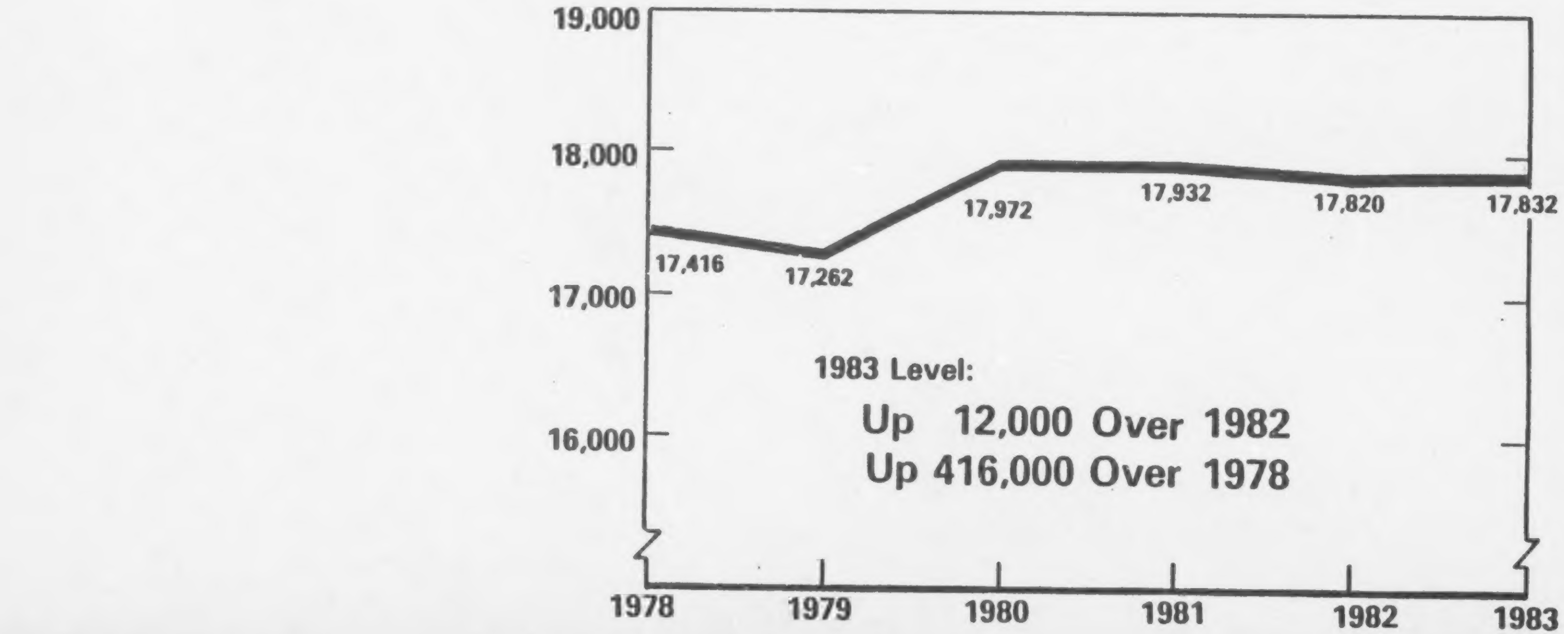


1983 Level:
Improved By:

0.2 Day From 1982
4.0 Days From 1978

Veterans
Administration

Medical Outpatient Visits
(In thousands)



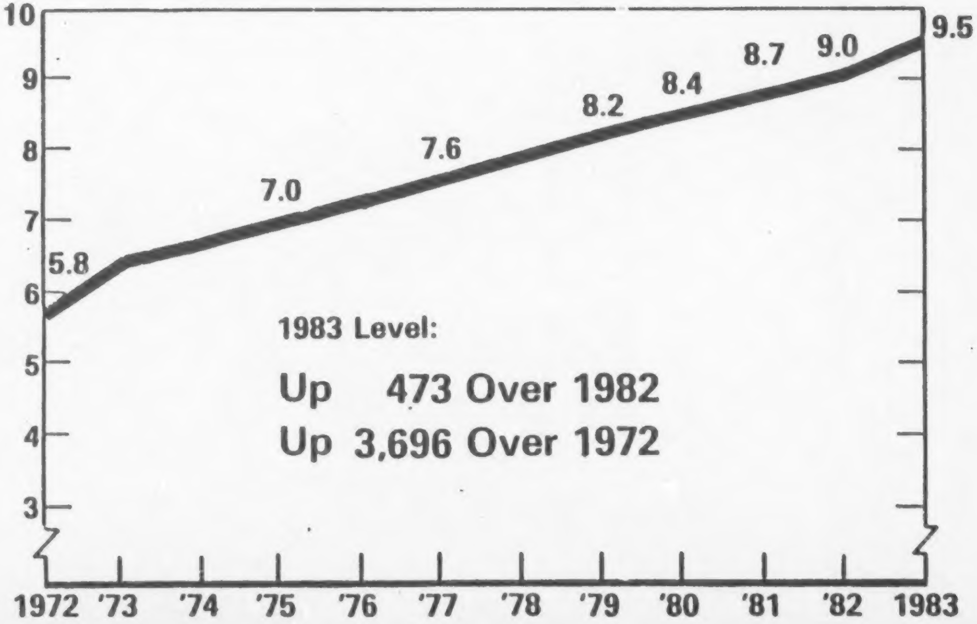
1983 Level:

Up 12,000 Over 1982
Up 416,000 Over 1978

Veterans Administration

Operating Beds - Average
VA Nursing Homes

(In thousands)



1983 Level:

Up 473 Over 1982

Up 3,696 Over 1972

Veterans
Administration

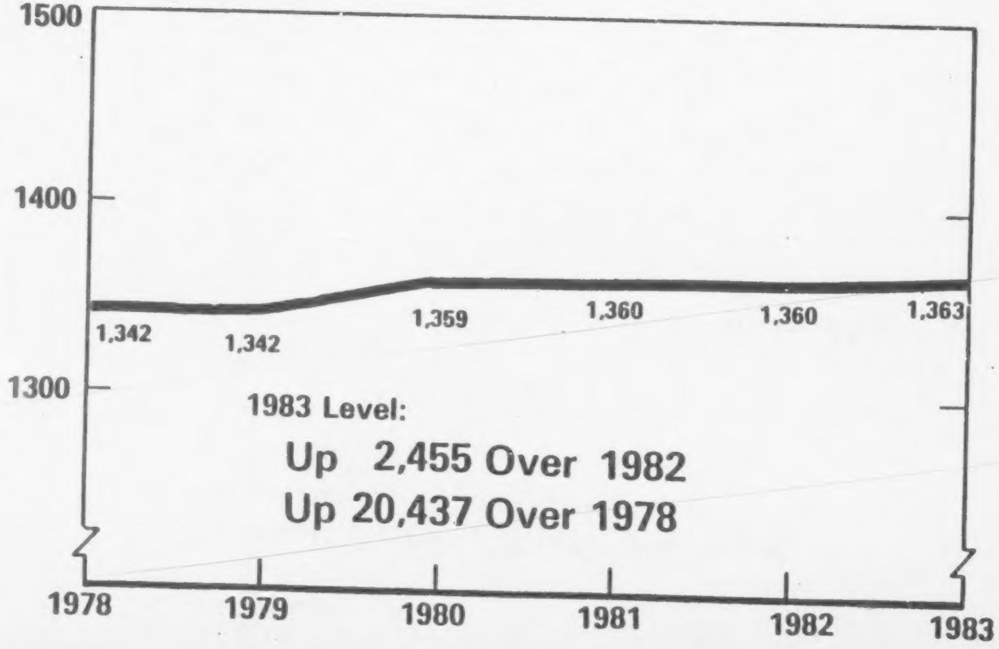
VA Nursing Home Activations

	Beds
FY 1982:	
Gainesville, Florida	120
Atlanta, Georgia	120
Livermore, California	120
FY 1983:	
Richmond, Virginia	120
Hines, Illinois	120
Wilkes-Barre, Pennsylvania	120

Veterans
Administration

Inpatient Care - Beneficiaries Treated

(In thousands)



1983 Level:

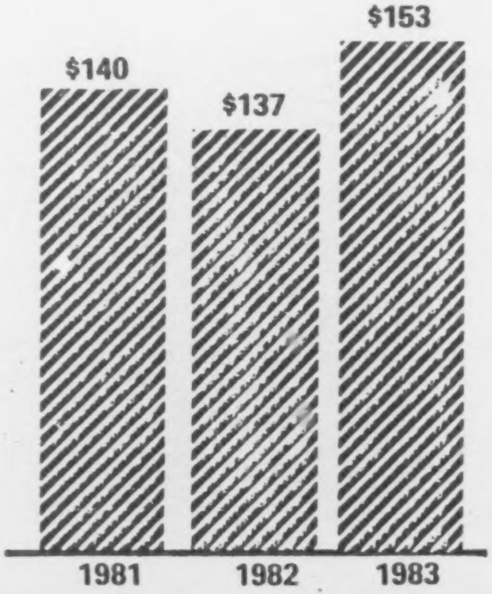
Up 2,455 Over 1982
Up 20,437 Over 1978

Veterans Administration

Medical and Prosthetic Research

(Appropriations in millions)

Up $16.0



- Average employment up 303 to 4,385
- Funding up $16.0 million:

• Medical Research	$ +12.4
• Rehabilitation Research	+ 2.7
• Health Services Research	+ .9
Total	$ +16.0

- Maintain High Priority Programs :
  - Schizophrenia
  - Alcoholism
  - Rehabilitation
  - Herbicide Orange
  - Spinal Cord Injury
  - Aging

RESEARCH BACKUP

Medical: Increase of $12,413,000 and 150 FTEE.

- Congress provided $2,536,000 to support specific Agent Orange activities.

Twin Study..........................	$2,000,000
Chloracne...........................	55,000
Agent Orange Program Support.......	278,000
Mortality Study....................	123,000
Follow-up to Literature Analyses...	45,000
Monograph Studies..................	35,000
	$2,536,000

- Investigator-Initiated research increased by $6.5 million and 88 FTEE. Resources will be utilized to support new programs of the highest scientific merit as well as continued support to ongoing programs.

- Cooperative Studies increase by $1 million and 20 FTEE and will support two additional studies in 1983.

- Career Development will receive an additional $1 million and 17 FTEE to support 10 additional programs.

- High Priority research increased by $715,000 and 25 FTEE and will support Agent Orange and Alcoholism studies.

- The remaining $641,000 is attributed to uncontrollable increases for payroll and inflation.

Rehabilitation: Increase of $2,695,000 and 126 FTEE.

- Resource totalling $1 million and 75 FTEE will be directed towards 12 solicited research programs related to prosthetic limbs, wheelchairs, and reading and travel aids for the blind.

- Investigator-Initiated projects will receive increased support. Approximately $1.1 million and 26 FTEE will be available for an additional 12 spinal cord injury, sensory aids, and prosthetics/amputation projects.

- $198,000 will be directed towards support of interagency agreements.

- The remaining 25 FTEE will be used to support Rehab R&D Centers.

- Uncontrollable increases will require $395,000.

Increase of $900,000 and 27 FTEE.

- Investigator-Initiated and Field program activities will be increased by $755,000 and 22 FTEE.

- $45,000 and 5 FTEE will be used to initiate collaborative research.

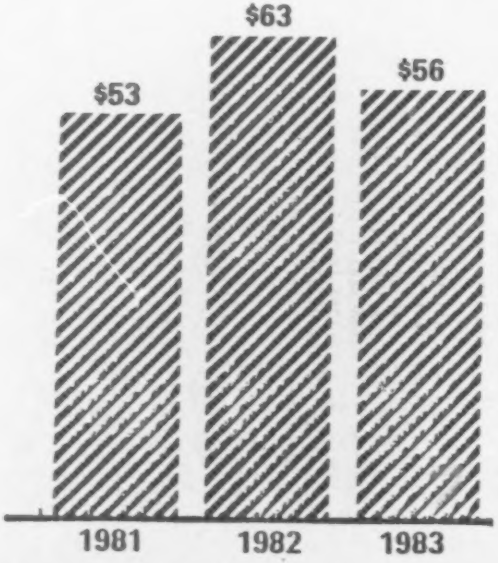
- The balance of $100,000 reflects uncontrollable increases.

Veterans Administration

Medical Administration and Miscellaneous Operating Expenses

(Appropriations in millions)

Down $7.6



- Average employment at 1982 level of 866
- Funding down $7.6 million:

• Medical Administration	$+2.5
• Postgraduate and Inservice Training Increases	+1.5
• Grants (Health Professional Scholarships Program)	- 11.6
Total	$ -7.6

MAMOE BACKUP

1. The 1983 net funding increase of $2.5 million in Medical Administration relate to the following:

    - Congressional action provided 13 FTEE increasing the MAMOE FTEE to the 1982 level of 866. Although no resources were provided for the 13 FTEE, congressional action directed that Medical Administration resources be realigned to support the Health Professional Scholarship program. This resulted in $415,000 being transferred from Medical Administration to the Health Professional Scholarship program to support the 13 FTEE.

    - A realignment of existing staff elements in Central Office resulted in a $485,000 reduction in required resources.

    - A transfer of funding responsibility for Supply Fund overhead costs to other VA appropriations, reduced 1983 requirements by $1,900,000.

    - Resources in support of Public Law 96-330, which includes such requirements as special pay for physicians and dentists and studies to be made relating to special pay and nurse recruitment, requires an increase of $1,940,000.

    - A contract to study the feasibility of collecting fees for user charges for medical services provided at VA health care facilities to non-service-connected veteran beneficiaries, who are not in receipt of a VA pension, requires $500,000.

    - The impact of inflation, payroll, and other uncontrollable increases on programs administered by existing staff elements, requires additional resources totaling $2,879,000.

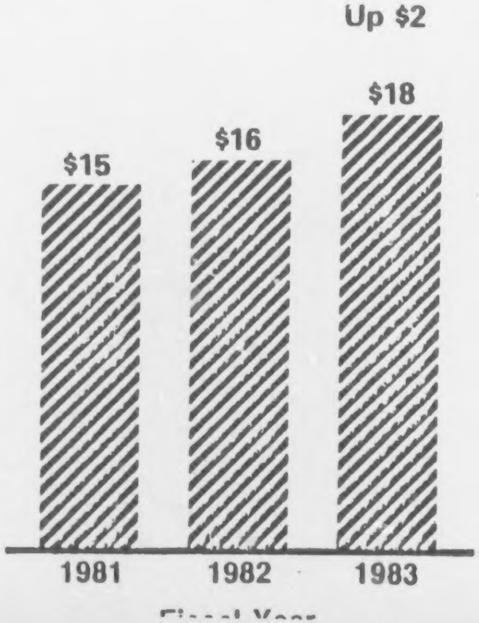
2. In the postgraduate and inservice training program, an increase of $1.5 million is required in 1983. Of this amount, 49 percent will offset the operational cost increase caused by inflation. The remaining funds will improve effectiveness of the VA Deparment of Medicine and Surgery's educational program and its impact on employee performance and patient care.

3. The decrease of $11.6 million in the Health Professional Scholarship Program is attributed to the fact that the Agency did not request or require resources for the program in 1983. The Agency requested $4 million to implement the program in 1982. This amount was increased to $12 million by Congressional action and made available through 1983. Congress also provided resources in 1983 ($415,000) for the administrative support of this program. The decrease of $11.6 results from the $12 million reduction in scholarship partially offset by the $415,000 provided for administrative

Veterans Administration

Grants for Construction of State Extended Care Facilities

(Dollars in millions)



- Provides for construction of new Domiciliaries and Nursing Homes, as well as remodeling existing facilities
- Program extended by PL 96-251 through 1986
- In 1983:
  - Construct 150 new beds, $4.5
  - Improve and renovate existing State home facilities, $1.4
- Obligations:

1981	1982	1983
$11.7	$19.3	$5.9

OPERATIONAL ISSUE
ADP
(DOLLARS IN THOUSANDS)

PROBLEM

DM&S ADP NEEDS FY 1983	$51,388
900 LIMITATION	29,395
CONGRESSIONAL LIMITATION	35,000

- CONGRESS IMPOSED A $35 MILLION LIMITATION ON THE AMOUNT THE VA MAY OBLIGATE FOR MEDICAL AUTOMATED DATA PROCESSING SERVICES WITHOUT THE APPROVAL OF THE COMMITTEES OF APPROPRIATION.
    - COMMITTEES AGREE WITH DIRECTION BUT QUESTIONS CONCERNING BEST SYSTEM, TOTAL COST AND IMPLEMENTATION TIMETABLE HAVE NOT BEEN FULLY ANSWERED.
- OMB 900 LIMITATION FURTHER COMPLICATES PROBLEM.
- DEPARTMENT PROBLEM - HOW DO WE OPERATE WITH A LIMITATION THAT DOES NOT SUPPORT CURRENT SERVICES?

SOLUTION

- SHORT-TERM - THE DEPARTMENT WILL IMPLEMENT A MECHANISM TO CONTROL 1983 MEDICAL ADP OBLIGATIONS TO INSURE THE CONGRESSIONAL LIMITATION IS NOT EXCEEDED.
- LONG-TERM - THE DEPARTMENT WILL JUSTIFY TO THE FULL SATISFACTION OF THE COMMITTEES THE NEED FOR THE FY 1983 REQUEST FOR MEDICAL ADP FUNDING AND HAVE THE COMMITTEES LIFT THE CAP LIMITATION.

OPERATIONAL ISSUE
1983 PAYROLL NEEDS
(DOLLARS IN THOUSANDS)

PAY RAISE/PAYROLL RELATED EXPENSES

	CIVILIAN PAY	WAGE BOARD	MEDICARE	FEHB	TOTAL
A) REQUIREMENT					
MEDICAL CARE......	$147,488	$13,000	$33,220	$19,428	$213,136
RESEARCH..........	4,237	75	642	451	5,405
TOTAL REQUIREMENT.....	151,725	13,075	33,862	19,879	218,541
B) ALLOWANCE					
MEDICAL CARE......	73,744	13,000	...	...	86,744
RESEARCH..........	2,119	75	...	...	2,194
TOTAL ALLOWANCE.......	75,863	13,075	...	...	88,938
C) SHORTFALL					
MEDICAL CARE......	73,744	...	33,220	19,428	126,392
RESEARCH..........	2,118	...	642	451	3,211
TOTAL SHORTFALL.......	75,862	...	33,862	19,879	129,603

ASSOCIATED PROBLEMS

- CONFERENCE REPORT ACCOMPANYING THE 1983 APPROPRIATION BILL DIRECTS FOR EACH APPROPRIATION THAT, THE AMOUNT OF FUNDING IS SPECIFICALLY INTENDED TO SUPPORT THE BUDGETED LEVEL OF FTEE AND ANY ADDITIONAL PAY NECESSARY TO SUPPORT THE FTEE LEVEL WILL BE BORNE BY THE VA, USING FUNDS MADE AVAILABLE BY THIS APPROPRIATION, SUPPLEMENTAL FUNDING OR ABSORPTION, OR SOME COMBINATION THEREOF.
- OMB WILL ALLOW A SUPPLEMENTAL REQUEST AS INDICATED IN B ABOVE, WHILE AT THE SAME TIME PROVIDING THE TOTAL FTEE CEILING INDICATED IN THE APPROPRIATION BILL.
- DEPARTMENT PROBLEM - HOW DO WE SUPPORT THE INDICATED LEVEL OF FTEE WITH INADEQUATE PERSONNEL SERVICES/DOLLAR SUPPORT?

RESEARCH SOLUTIONS

- REDUCTION IN SUPPLIES AND EQUIPMENT
- REDUCTION IN INVESTIGATOR-INITIATED CAREER DEVELOPMENT AND COOPERATIVE STUDIES PROGRAM.
- REDUCTION OF PROGRAMS IN FUNCTIONAL ELECTRICAL STIMULATION RESEARCH FOR SPINAL CORD INJURY.

MEDICAL CARE SOLUTIONS

SHORT TERM (1983)

- FULLY FUND ALL FTEE FROM CO ACCOUNTS
- WITHDRAW $8 MILLION FROM FIELD BASED ON REVISED ECONOMIC ASSUMPTIONS (ONE HALF OF 1%) ?
- SEVERELY RESTRICT CAPITAL ACCOUNTS IN CO
- LARGE EQUIPMENT PURCHASES WILL BE SEVERELY RESTRICTED AND ITEMS SUCH AS TELEPHONES, LAUNDRIES, AND MAJOR ITEMS OF UNFUNDED EQUIPMENT NEEDS WILL BE NON EXISTENT.

LONG TERM (1984)

- ASSUMPTION IS THAT ABSORPTIONS FOR MEDICARE AND FEHB WILL BE RECURRING
- WILL REQUIRE $73 MILLION
- TO OFFSET THESE FUNDING LOSSES, THE VA WILL ATTEMPT TO REDUCE NON-VA PROGRAMS, INCLUDING FEE MEDICAL, FEE DENTAL, AND CONTRACT HOSPITALIZATION.

PHILOSOPHY

- HEREAFTER, IF YOU NEED MONEY, "DON'T CALL US WE'LL CALL YOU"

Com: VA: Budget: Medical

November 18, 1982

Honorable Robert Nimmo
Administrator (00)
Veterans Administration
Washington, DC 20420

Dear Mr. Administrator:

The Fiscal Year 1983 Appropriation for Medical Care contained an increase of $410 million over Fiscal Year 1982 and added 1,759 FTEE. The Medical and Prosthetic Research Program contained an increase of some $16 million and an additional 303 FTEE.

I am aware of the 4% cost-of-living adjustment for Federal employees that became effective on October 1, 1982, as well as the coverage of Federal employees under Medicare and the increased costs of Federal health benefits programs which became effective January 1, 1983. I am interested in learning what impact any of these programs and increases will have on the Medical Care and Medical and Prosthetic Research Appropriations for the current fiscal year. Specifically, will the VA be required by the Office of Management and Budget to absorb any of the costs; and if so, what percentage will have to be absorbed? Will the VA be permitted to include any of these costs in a supplemental appropriations request? Further, we are interested in learning what the impact will be on the increased FTEE in the appropriations for FY '83 in both Medical Care and Medical and Prosthetic Research.

I would appreciate your furnishing this information at an early date in order that the Committee on Veterans' Affairs might review it to insure that the quality of health care delivered to veterans is maintained.

Sincerely,

G. V. (SONNY) MONTGOMERY
Chairman

RTC:bae

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

DECEMBER 2 - 1982

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Sonny,

Thank you for your letter of November 19, 1982, requesting information as to whether OMB will require the VA to absorb any of the increased costs of this October's Federal employee pay raise, as well as Medicare coverage and Federal health benefits cost increases.

I share your concern for insuring that the quality of health care delivered to veterans is maintained and I plan to continue to deal with OMB as a firm advocate of the best interests of this Agency and all the veterans it serves. We are currently in the process of negotiation with OMB and therefore the questions you have asked have not as yet been finally resolved within the Administration. I will not be able to disclose the information you requested until the President formally transmits a supplemental appropriation request in January.

I will reply to you in full as soon as possible.

Sincerely,

Everett Alvarez Jr.

ROBERT P. NIMMO
Administrator

Deputy Administrator For

Cannon House Office Building
Room 131
Washington, D.C. 20515

Administrative Assistant
RICHARD McBRIDE

Legislative Assistant
JAMES E. LAMBLE

District Offices:
701 Clematis Street
Suite 321
West Palm Beach, Florida 33401

550 North State Road 7
Margate, Florida 33063

DANIEL A. MICA
11th District, Florida

Congreſs of the United States
House of Representatives
Washington, D.C. 20515

Foreign Affairs

Veterans' Affairs

Select Committee on
Aging

November 30, 1982

Mr. Robert P. Nimmo
Administrator
Veterans Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Mr. Administrator:

It has been brought to my attention that the Veterans Administration's thirty year study of the medical needs of veterans in Florida has been delayed.

As you know, Public Law 97-101, enacted in December 1981, authorized the VA to study the medical needs of Florida's growing veterans population. I want you to know how important this study is to the veterans of Florida and urge you to complete your report immediately.

I would greatly appreciate further information regarding the delay of this study as well as an estimated date of completion. In addition, I would like to request a copy of the report as soon as it is available.

Your immediate attention to this matter would be appreciated.

With kind regards,

Sincerely yours,

DANIEL A. MICA, M.C.

DM: st

RECEIVED
DEC 2 1982
CENTRAL OFFICE
CONGRESSIONAL RELATIONS STAFF

THIS STATIONERY PRINTED ON PAPER MADE WITH RECYCLED FIBERS

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

**Veterans
Administration**

NOVEMBER 30 1982

NOV 30 1982

Honorable G. V. "Sonny" Montgomery
Chairman
Committee on Veterans Affairs
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

We are aware of and most sensitive to the congressional requirement that three reports be submitted by the Veterans Administration to the Veterans' Affairs Committees by December 1, 1982. These reports are:

- A Plan for Delivery of Health Care to Veterans in Puerto Rico and the Virgin Islands;
- Admissions and Rejections for VA Health Care, the Adequacy of VA Operating Beds, and Related Subjects, as Required by P.L. 97-72, Section 108; and,
- A Thirty-Year Study of the Needs of Veterans in Florida.

We regret we are unable to meet the due date for this reporting requirement. All three of these reports, as you know, involve resource requirements and consequently are tied to the Medical District Initiated Program Planning (MEDIPP) process. Because of the need for coordination with MEDIPP, and the MEDIPP schedule for data collection, we have been unable to match the data to the degree that will assure the highest possible quality of conclusions and recommendations. We believe the extra time required to refine these reports will be well worth the delay.

Except for final reconciliation of the data materials and the executive branch review, they are ready for submission to your committee. It is our expectation that these reports can be transmitted to you within 45 days.

Sincerely,

Everett Alvarez Jr.

ROBERT P. NIMMO   Deputy Administrator For
Administrator

HOSPITALS: CONSTRUCTION (related corres attached)

November 16, 1982

Honorable Dan Mica
U. S. House of Representatives
Washington, D. C. 20515

Dear Dan:

Enclosed is a copy of a letter I recently received from Dr. Donald L. Custis concerning the status of the Veterans Administration's study of the health care needs of veterans in Florida.

It would appear that we will have a final report on the study no later than November 30th. That report may be submitted to you directly; however, should it come to me, I will certainly refer it on to you immediately.

Sincerely,

G. V. (SONNY) MONTGOMERY
Chairman

MF: clg

Department of Medicine
and Surgery

Washington D.C. 20420

Veterans
Administration

NOV 4 1982

In Reply Refer To: 10C2A

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans' Affairs
House of Representatives
Washington, DC 20515

NOV 5 1982

Dear Mr. Chairman:

I am pleased to respond to your inquiry on behalf of Congressman Mica, concerning the status of the Veterans Administration's study of the health care needs of veterans in Florida.

As you know, the study is expected to be completed by November 30, 1982. At the present time, we have met all of the target dates given to the Committee on Veterans' Affairs in the report Congressman Mica cites. The conclusions of the study, however, are still in a preliminary state and no interim report has been prepared. We anticipate no problems in completing the report.

Thank you for your continuing interest.

Sincerely,

DONALD L. CUSTIS, M.D.
Chief Medical Director

Hospitals: Construction (March 12 letter to Mr. Mica attached)

October 12, 1982

Donald L. Custis, M.D.
Chief Medical Director
Veterans Administration
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Custis:

Enclosed is a copy of a letter from my colleague Dan Mica, a Member of the Committee on Veterans' Affairs, concerning the study being conducted on the anticipated requirements for VA health care services in the State of Florida.

I would appreciate your advising me of the status of this study. In addition, please furnish me an interim report, if such is available at this time, that I might pass on to Mr. Mica.

Sincerely,

G. V. (SONNY) MONTGOMERY
Chairman

MF:ab

Hospitals: Construction (March 12 letter to Mr. Mica attached)

October 12, 1982

Honorable Dan Mica
U. S. House of Representatives
Washington, DC 20515

Dear Dan:

Thank you for your letter of October 4 requesting that I obtain from the Veterans Administration an interim report on the study on anticipated requirements for VA health care services in Florida. You will recall this study was mandated as part of the report leading to the implementation of Public Law 97-101. The study is scheduled for completion by November 30, 1982.

I have contacted the Chief Medical Director to determine if an interim report is available and, if so, shall pass it on to you. Otherwise, when the report is completed in November, I plan to meet with you to determine what course of action to take next Session when scheduling our legislative and oversight hearings.

I continue to appreciate your good work on behalf of veterans in the State of Florida and the southeast region, and look forward to working with you during the next Congress as we prepare to deal with this issue.

Sincerely,

G. V. (SONNY) MONTGOMERY
Chairman

MF:ab

Cannon House Office Building
Room 131
Washington, D.C. 20515

Administrative Assistant
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Legislative Assistant
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DANIEL A. MICA
11th District, Florida

Congreſs of the United States
House of Representatives
Washington, D.C. 20515

Foreign Affairs

Veterans' Affairs

Select Committee on Aging

October 4, 1982

OCT 6 1982

Chairman G.V.(Sonny)Montgomery
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Sonny:

I am writing in regards to a matter of great concern to me and the veterans of Florida.

As you know, the Veterans' Administration is presently conducting a study of hospital and health care facilities in the state of Florida. According to the report you received from the VA and shared with me on March 12, 1982, the VA has now reached its target date for analyzing the need for additional expansion of VA health care facilities in Florida. I would greatly appreciate it if you would kindly have the committee request an interim report on the status of this study.

Your assistance in this matter is greatly appreciated.

With kind regards and best wishes,

Sincerely yours,

DANIEL A. MICA, M.C.

DM: st

THIS STATIONERY PRINTED ON PAPER MADE WITH RECYCLED FIBERS

PROGRESS REPORT ON IMPLEMENTATION OF P.L. 97-101

The Senate Report #97-163 (page 90) has directed the VA to make an in-depth study of the state of Florida at the medical district level of the anticipated requirements for VA health-care services and the adequacy of existing facilities to meet that demand. The study shall include a 30-year projection of the demand for VA health-care services in Florida, a survey of existing VA-operated health care facilities in that state, and an analysis of the need for expansion and, if necessary, a plan to carry out such expansion of the VA's medical program in Florida. The proposed actions will be carried out by the medical district planner in coordination with Health System Information Service, as an integral part of the Medical District Initiated Program Planning process.

	Proposed Actions	Target Dates
1.	Initial Baseline Data Information MEDIPP Package (District 13)	1/30/82
2.	Determine 30-year projection for veteran population.	5/31/82
3.	Prepare projection for each VAMC, outpatient clinic, nursing home and domiciliary in Florida.	8/31/82
4.	Survey adequacy of existing facilities to meet the projected needs of Florida.	8/31/82
5.	Analysis of need for additional expansion.	9/30/82
6.	Develop plan to carry out necessary expansion.	10/30/82

The following progress has been made:

1. An updated procedure for determining historical and future veteran population has been developed. This procedure incorporates more recent migration information than the current procedure.
2. Refinements to the bed sizing model that will simplify VAMC projections have been made. In addition, methodologies for assessing nursing home care and domiciliary needs have been formulated.

Health System Information Service will prepare a report to Congress on the results of the 30 year study by November 30, 1982.

10C3
3/8/82

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10C3
3/8/82

A
THIRTY
YEAR STUDY
OF THE
NEEDS OF
VETERANS IN
FLORIDA

(PURSUANT TO THE REQUIREMENTS OF P.L. 97-101)

Prepared by:
Veterans Administration
Department of Medicine and Surgery

EXECUTIVE SUMMARY

Language accompanying Public Law 97-101 directed the Veterans Administration to conduct a study of the health care requirements of veterans in the State of Florida over a 30 year horizon. In addition, the language requested an analysis of anticipated deficits in current facilities to provide the needed services, and a plan to develop the resources necessary to meet the need.

This report presents the study results. It includes sections on demographics, current resources, projected health care needs for the future and a plan for meeting these needs.

Additional resources are needed to meet the future health care needs in Florida and must come either from a major shifting of existing resources or additional appropriations. The total cost for the elements of the strategy outlined in this report would require approximately $432.7 million dollars for construction and equipment and an additional $242.6 million per year for recurring/operating costs.

Most of the information contained in this report is based upon the preliminary findings from the VA Department of Medicine and Surgery's grass roots planning effort called Medical District Initiated Program Planning (MEDIPP). MEDIPP is the VA's advance planning effort to prepare for the medical needs of veterans in the years 1985-1990. The preliminary findings from each of the VA's 28 medical districts are currently being assessed to determine the relative needs of the VA's health care system as a whole. For A Thirty Year Study of the Needs of Veterans in Florida, health care requirements were developed using MEDIPP planning techniques for the years 1990, 2000, and 2010. The accuracy of any long range planning methodology decreases over time and this general principle is true for the projections of this study. However, the general trends indicated by the data are considered reliable, although the specific projections for the outlying planning horizons must be viewed with caution.

Florida is one of the fastest growing states in the United States. The veteran population is expected to grow 12% by the year 1990. The veteran population is also shifting within the state, however, the impact of these shifts on the provision of health care is not entirely known yet.

Currently the VA has a total of 3,054 hospital beds at five different locations in Florida. This is the equivalent of 2.0 beds oer thousand veterans compared to 3.0 beds per thousand nationally. Total outpatient visits for Florida in FY 1981 were 906,040. 55% of these outpatients were service connected beneficiaries as compared with 44% nationally. The VA also has 520 VA nursing home beds and 200 domiciliary beds in Florida.

Non-VA health care resources in Florida include community hospital and nursing home beds which are expected to be in short supply by 1990 due to increased demand generated by significant increases in the non-veteran population in Florida. In addition, the Department of Defense has numerous authorized beds and outpatient sites in the State of Florida and there is potential for establishing sharing agreements to make some of these resources available to VA patients.

The peak demand for veteran health care needs in Florida is projected to occur in the year 2000. After that year demand decreases sharply, but those projections are less accurate because of the long planning horizon involved. However, the indication of an overall downward trend in demand is considered accurate. The projections for the year 2000 and the difference between 2000 and 1981 are as follows:

Requirements for 2000	Increase for 1981
4399 inpatient beds	(+1,483)
1,493,400 outpatient visits	(+587,900)
2,688 VA owned and operated NHC beds	(+2,168)
4031 community and state NHC beds	(+3,598)
550 domiciliary beds	(+350)

Various factors guided the formulation of the specific plan elements contained in this report. These were:

1. Non-construction alternatives will be used to the extent possible.

2. Maximum size of nursing homes located adjacent to a hospital will be 240 beds. A satellite outpatient clinic can support a maximum of 120 nursing home care beds.

3. New construction will be inexpensive, easily convertible to nursing home care and built in the fastest growing areas of the State which now have limited access to care.

4. Although medical care needs peak in 2000; planning needs should be based on the needs between the years 1990-2000, in order to minimize excess capacity in non-peak years.

5. The need considered most urgent within Florida is for extended psychiatric beds.

6. Public Law 97-174 directs the VA and the Department of Defense to explore the possibilities of sharing medical resources.

Plan elements developed are as follows:

1. Construct 290 psychiatric beds at existing VA Medical Center Gainesville.

2. Convert space to accommodate 42 extended psychiatry beds at existing VA Medical Center Miami.

3. Establish 1,000 additional hospital beds.

4. Construct 800 VA owned and operated nursing home care beds.

5. Encourage the construction of a State nursing home.

6. Contract for an additional 1,324 average daily census in community nursing homes.

7. Increase the outpatient funding ceiling to meet the needs of the same percentage of service connected veterans in Florida as in the nation.

8. Establish two additional outpatient clinics as well as continue plans for activating clinics at Pensacola and Daytona Beach.

9. Lease or contract additional domiciliary beds.

10. Develop residential care programs.

11. Establish community and VA sponsored Geriatric Day Care Center.

12. Increase home health services.

13. Assess the capacity for sharing with the Department of Defense and enter into agreements as appropriate.

INTRODUCTION

This report is being submitted in response to a directive accompanying Public Law 97-101, enacted December 23, 1981.

> "The Committee notes that certain growth and improvements in the VA medical program - either through renovation of existing facilities or through new construction - will very likely be necessary as a result of the very rapid rate of growth in the veteran population in the State of Florida. The Committee recognizes the importance of VA planning efforts to assess demographic changes in order to effectively meet existing critical needs as well as expected dramatic increases in demand for VA health care services in the State of Florida. The Committee believes that an indepth study at the medical district level of the anticipated requirements for VA health care services and the adequacy of existing facilities to meet that demand would greatly enhance these planning efforts. Thus, the Committee directs the VA to undertake such a study. The study shall include a 30-year projection of the demand for VA health care services in Florida, a survey of existing VA operated health care facilities in that State, and an analysis of the need for expansion - and, if necessary, a plan to carry out such expansion of the VA's medical program in Florida."

This report presents a study of the health needs of veterans in Florida at 10 year intervals over a 30 year horizon. As in any type of long-term planning the accuracy of any projection methodology decreases as the time horizon increases. Therefore, the projections made in this study are most accurate for 1990 and least accurate for 2010.

The State of Florida includes parts of two VA medical districts. Medical District 10 covers 8 counties in the panhandle area of Florida, while Medical District 12 covers the rest of Florida, and an additional 19 counties in Georgia (see Appendix A). For the purpose of this study all of Medical District 12 is included as well as Florida counties from Medical District 10.

This analysis includes a discussion of current resources, the need for expansion for the future and options to meet these needs including both construction and non-construction alternatives. All of the options presented require additional resources. These resources must either come from additional appropriations or through a major shifting of resources from other geographical regions of the U.S. at a time when the increasing needs of the aging veterans throughout the country will be taxing the resources of the VA. The total cost for the elements of the strategy outlined in this report are 242.6 million dollars in recurring costs, and 432.7 million dollars for construction and initial equipment. This cost estimate does not include the cost savings which would result from sharing agreements with Department of Defense health facilities.

Information concerning the health care needs of veterans through 1990 included in this study reflects preliminary results from the Medical District Initiated Program Planning (MEDIPP) plans from Medical Districts 10 and 12. This grass roots planning program is based on the premise that local knowledge of demand, resource needs and existing capabilities will result in more efficient services and better resource utilization than decisions based on planning which is solely centrally directed. The VA, therefore, has assigned to each of its 28 medical districts the responsibility for developing plans based upon veteran population, other demographic data and workload trends of the individual facilities. The specific planning work is accomplished by District Planning Boards consisting of clinical and administrative representatives of the VA facilities in the area.

It must be emphasized that the information in this report is of a preliminary nature representing the VA's advance planning effort to prepare for the medical needs of veterans in the years 1985 to 1990. Therefore, the information included in this report is subject to revision as each annual planning cycle is completed.

DEMOGRAPHIC/SOCIO-ECONOMIC DATA ON THE STATE OF FLORIDA

The State of Florida has 67 counties and covers 58,560 square miles of land area.

Florida is one of the fastest growing states in the Union. According to the U.S. Bureau of Census, Florida's civilian population increased from 6,791,418 persons in 1970 to 9,739,992 persons in 1980. This represents a growth rate of 43.4 percent during this ten (10) year period.

In 1981, the State of Florida had an estimated 1,525,543 veterans. By 1990, this population is projected to increase some 177,937 veterans or 12 percent to approximately 1,703,480. Due to the heavy in-migration of elderly population to sunbelt states like Florida, approximately 41 percent of this projected veteran population will be age 65 years and older.*

Currently, there are 18 urban or standard metropolitan statistical areas (SMSA) in the State of Florida. These urbanized areas contain only 28 of the 67 counties, but 90 percent of the estimated veteran population within the State of Florida. The remainder of the veteran population (10%) resides in 39 counties classified as rural. The number of veterans living in these urban areas ranged from a high of 228,285 in Miami SMSA to a low of 13,477 in Ocala SMSA in 1981. Among the top ten SMSAs, Miami shows the largest increase in the number of veterans (23,755) between 1981 and 1990, while Pensacola shows the greatest percentage (15.6%) increase (see Table 1). Shifts in veteran population are expected to occur beyond 1990, although the actual impact of these shifts is not currently known.

*These population figures include the nineteen counties listed in Appendix A.

TABLE I
VETERANS POPULATION BY SMSA: FLORIDA, 1981 AND 1990

					CHANGE	
SMSA	1981	RANK	1990	RANK	NUMBER	PERCENT
Miami	228,285	1	252,040	1	23,755	10.4
Tampa - St. Petersburg	222,860	2	243,990	2	21,130	9.5
Jacksonville	137,374	3	156,930	3	19,556	14.2
Fort Lauderdale-Hollywood	131,255	4	142,560	4	11,305	8.6
Orlando	106,916	5	122,010	5	15,094	14.1
West Palm Beach - Boca Raton	68,886	6	74,830	6	5,944	8.6
Melbourne - Titusville Cocoa	56,212	7	63,670	7	7,458	13.3
Pensacola	51,993	8	60,090	8	8,097	15.6
Lakeland-Winter Haven	43,453	9	47,670	9	4,217	9.7
Daytona Beach	33,823	10	36,630	10	2,807	8.3
Tallahassee	23,565	11	27,880	11	4,315	18.3
Gainesville	21,628	13	25,650	12	4,022	18.6
Sarasota	22,661	12	23,560	13	899	4.0
Fort Myers - Cape Coral	21,213	14	23,000	14	1,787	8.4
Fort Walton Beach	17,067	16	20,440	15	3,373	19.8
Panama City	16,335	17	18,980	16	2,645	16.2
Bradenton	17,292	15	18,340	17	1,048	6.1
Ocala	13,447	18	14,990	18	1,543	11.5
TOTAL URBAN	1,234,265	—	1,373,260	—	138,995	11.3
TOTAL RURAL	134,554	—	146,740	—	12,186	9.1
STATE OF FLORIDA	1,368,819	—	1,520,000	—	151,181	11.0
% URBAN	90.2%	—	90.3%	—	—	—

SOURCE: Veterans Administration, Reports and Statistics Service

Civilian per capita income in the State of Florida increased from $8,034 in 1979 to $10,050 in 1981; an increase of 25 percent. The per capita income for the U.S. increased from $8,638 to $10,517 during this same period; a 22 percent increase. Florida's per capita income in 1979 was 93% of that of the U.S. By 1981, the ratio had increased to 96% (see Table 2).

TABLE 2.
PER CAPITA PERSONAL INCOME DOLLARS

	1979	1980	1981
FLORIDA	$8,034	$8,993	$10,050
U.S.	$8,638	$9,511	$10,517
RATIO*	.9301	.9455	.9556

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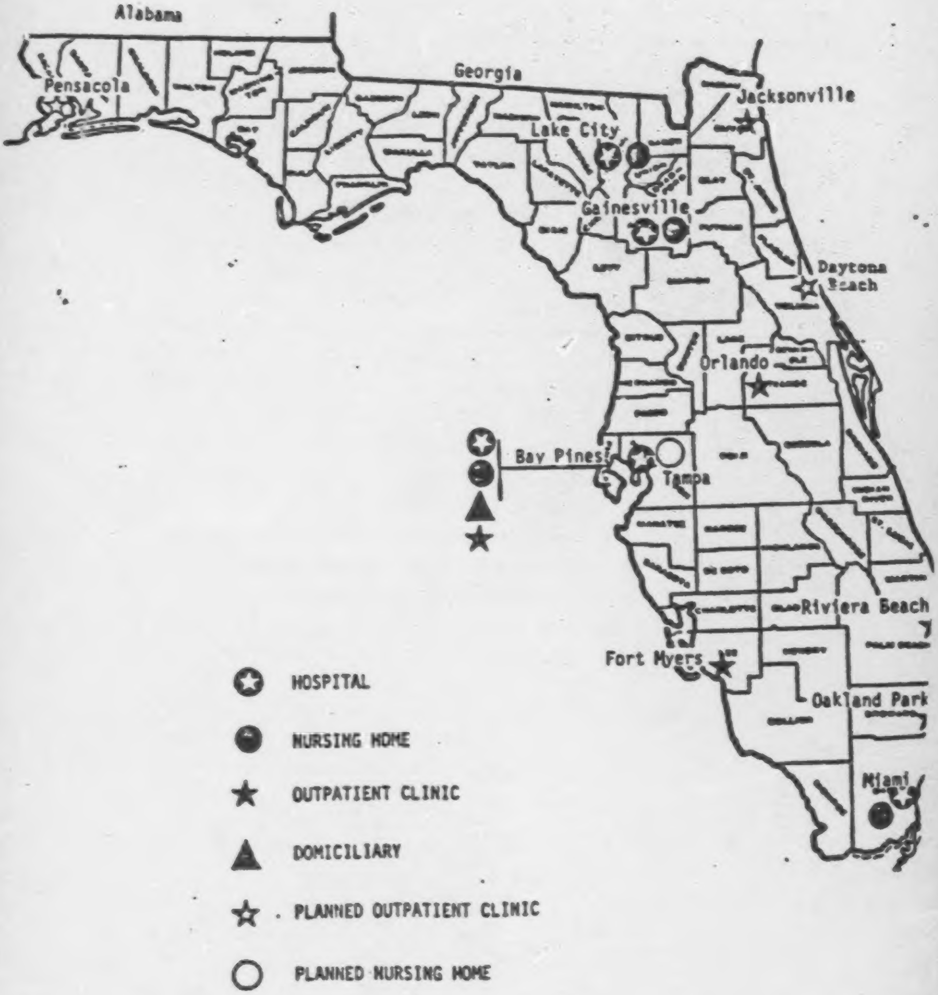
*Ratio of Florida's per capita income to that of the U.S.

SOURCE: U.S. Department of Commerce/Bureau of Economic Analysis, Survey of Current Business, April 1982/Volume 62, Number 4.

VA MEDICAL CARE RESOURCES IN THE STATE OF FLORIDA


Alabama
Georgia
Pensacola
Jacksonville
Lake City
Gainesville
Daytona Beach
Orlando
Bay Pines
Tampa
Riviera Beach
Fort Myers
Oakland Park
Miami
HOSPITAL
NURSING HOME
OUTPATIENT CLINIC
DOMICILIARY
PLANNED OUTPATIENT CLINIC
PLANNED NURSING HOME

CURRENT

A. Veterans Administration Resources

The State of Florida has five VA Medical Centers (VAMC) located at Bay Pines, Gainesville, Lake City, Miami, and Tampa. In addition, satellite outpatient clinics are in operation in Fort Myers, Jacksonville, Oakland Park, Orlando, Riviera Beach, and St. Petersburg. These facilities serve an estimated veteran population of 1,525,543. Approximately ten years ago a need was identified for satellite outpatient clinics in the panhandle and Volusia County (Daytona Beach). A panhandle area clinic is scheduled for activation in July 1984 in Pensacola. The VA is presently taking preliminary steps to establish an outpatient clinic in Daytona Beach.

There are currently 3,054 VA owned and operated hospital beds in Florida or two beds per thousand veteran population compared to a national bed ratio of three. Total hospital discharges for 1981 were 54,754 representing hospital treatment of 35,915 patients or approximately 2% of the total veteran population. 36% of these patients are service connected (SC) compared with 30% of patients discharged nationally from VA hosptials.

Total outpatient visits for veterans in Florida in 1981 were 906,040. 55% of these patients were SC compared to a national average of 44%. The non discretionary workload in Florida outpatient clinics is higher than in any other district at 66.9% (non discretionary workload includes service connected outpatient treatment applicants for medical care and compensation and pension exams).

There are 520 VA owned and operated nursing home care beds in the state, 240 beds under construction at VAMCs Lake City and Tampa and 120 beds approved for construction in Miami in 1984. Additionally, in 1981 an average daily census of 433 patients were in community nursing home care beds under VA contract. There are 200 domiciliary beds in the state at the VAMC Bay Pines.

There are currently two VA operated hospital based home care programs in VAMC Bay Pines and Miami. During the first six months of FY 1982, 284 patients were treated for a total of 5,268 visits.

B. Community Resources

There are currently 46,642 licensed community hospital beds in the state. Applying the state's standard of need of 4.24 beds per 1000 to the projected population for 1990, there is a need for 52,045 total beds or an increase of 5,403 acute care beds. There are 45,676 licensed community nursing home care beds in the state. Applying the state's standard of 24.9 - 27 nursing home beds per 1000 population age 65 years and over for 1990, there is a need for 61,650 to 66,850 nursing home care beds or an increase between 15,974 and 21,174. Because of the extreme rate of growth of the general population and the projected need for community bed construction it is not realistic to believe that projected additional demand for VA workload can be absorbed by existing or future community resources.

There are currently 144 licensed community home health care agencies in the state. The need projection methodology for this service shows no indication of need to expand this service prior to 1990. If VA funds were made available for contracting this service, the community resources would be capable of taking on some additional workload.

C. Department of Defense Resources

There are nine military hospitals in the state with a total of 1,455 authorized beds. Each of these hospitals provides outpatient care. Additionally there are ten military outpatient clinics in the state. There was an average daily census of 590 in these hospitals in 1981. There were in excess of 2.7 million outpatient visits to these facilities in 1981. Table 2 is a display of types and locations as well as selected workload data on medical facilities. Although not yet investigated, there may be the potential for sharing resources with the military, for either inpatient or outpatient services.

Table 2
SELECTED DATA ON MILITARY MEDICAL FACILITIES IN FLORIDA

I. HOSPITALS

Name	County	Authorized Beds	Operating Beds	ADC	Outpatient Visits
Homestead Air Force Base	Dade	125	85	60	196,445
McDill Air Force Base	Hillsborough	150	75	52	239,624
Orlando Naval Base	Orange	104	84	64	378,894
Patrick Air Force Base	Brevard	75	25	16	135,864
Jacksonville Naval Base	Duval	376	177	147	394,116
Moody Air Force Base	Lowndes	35	25	18	91,402
Eglin Air Force Base	Okaloosa	200	145	111	361,887
Tyndall Air Force Base	Bay	80	35	28	140,576
Pensacola Naval Base	Escambia	310	115	94	248,836
Total		1,455	766	590	2,187,644

II. OUTPATIENT CLINICS

Name	County	Beds	Visits
Key West Navy	Monroe	0	14,706
Key West Air Force	Monroe	118	29,321
Mayport	Duval	6	100,834
Cecil Field	Duval	9	43,328
Orlando McCoy Annex	Orange	0	Not Reported
Panama City Navy	Bay	5	10,066
Pensacola Navy	Escambia	0	Not Reported
Pensacola Training Center	Escambia	0	64,986
Whiting Field	Escambia	6	100,834
Total		219	627,316

The need for veteran health care in the State of Florida is expected to increase both because of the growing veteran population and the increase in aging veterans whose utilization of VA resources is higher than younger veterans.

PROJECTIONS FOR THE STATE OF FLORIDA

Hospital Inpatient Care Provided Under VA Auspices

Projections of future hospital inpatient bed needs for the State of Florida were based upon a hospital bed sizing model agreed upon jointly by the VA and the General Accounting Office. (see Appendix B, page 21). This projection methodology is based upon a continuation of workload trends established over a four year period. To the extent that the trend of the historical utilization does not continue, projections will be inaccurate. The results indicate that by 2000, the State of Florida will require approximately 1,483 additional beds over the FY 81 authorized level of 2,916.** The major increases for 2000 will be in internal medicine (+636 beds), in intermediate medicine (+387 beds) and in psychiatry (+344 beds). While the projections show a significant drop in projected need for hospital beds in 2010, this out year projection should be viewed with extreme caution because projection techniques accuracy decreases over a long time horizon. These estimates in general are conservative because of the constrained demand in Florida.

Table 3
State of Florida Bed Distribution
Actual for 1981 versus 1990-2000-2010 Projections

	Authorized Beds 1981	Projected 1990	Difference 1990-1981	Projected 2000	Difference 2000-1981	Projected 2010	Difference 2010-1981
Inpatient**	2916	3935	+1019	4399	+1483	3135	+219
-Inter. Med.	1098	1541	+443	1734	+636	1213	+115
-Intermed.	211	508	+297	598	+387	420	+209
-Neuro.	70	73	+3	83	+13	59	-11
-Rehab. Med.	71	86	+15	102	+31	63	-8
-Surgery	929	871	-58	1001	+72	701	-228
-Psych.	537	856	+319	881	+344	679	+142

**Excludes 25 Dialysis, 113 SCI. Such beds are excluded because they are special programs which currently are centrally planned. The bed projection model is not suitable for projecting bed needs in these programs.

Outpatient Care Provided Under VA Auspices

Projections of future outpatient visit needs for the State of Florida were based upon an outpatient sizing model established by VA. (See Appendix C, page 22). The results indicate that by 2000, the State of Florida will require approximately 587,400 additional outpatient visits over the FY 81 level of 906,040 visits.

Table 4

State of Florida Outpatient Visits
Actual for FY 81 versus 1990-2000-2010 Projections

Year	Projected Visits	Difference From 1981
1981	906,040	
1990	1,276,995	+400,955
2000	1,493,440	+587,400
2010	1,065,168	+159,128

Nursing Home Care Provided Under VA Auspices

Projections of future nursing home care needs for the State of Florida were based upon VA Guidance (See Appendix D, page 23). The results are based upon the mid-range VA market share of 14% and a program mix of 40% VA owned and operated, 40% community contract beds, and 20% state home beds. The results indicate that by 2000, the State of Florida will require 2,168 additional VA nursing home beds ovet the FY 81 level of 520 VA NHCU beds, 2,255 additional community nursing home contract census over the FY 81 level of 433 census as well as the establishment of 1,343 state veteran home beds.

Table 5

State of Florida Nursing Home Distribution

	FY 81 Visits	1990	Difference 1981-1990	2000	Difference 1981-2000	2010	Differenc 1981-201
14% Market Share	953	3554	+2601	6719	+5756	4254	+330
VA	520	1422	+922	2688	+2168	1701	+11
CNHC	433	1422	+989	2688	+2255	1701	+12
STATE	0	710	+710	1343	+1343	852	+8

Domiciliary Care Provided Under VA Auspices

Projections of future domiciliary care needs for veterans in the state of Florida were based upon VA Guidance (see Appendix E, page 24). The results, based upon a 6% VA market share, indicates that by 2000, the State of Florida will require 350 additional domiciliary beds over the FY 81 level of 200 beds.

Table 6
State of Florida Domiciliary Needs

Year	Domiciliary Projected Beds	Difference From 1981 Beds
1981	200	
1990	503	303
2000	550	350
2010	389	189

CONSIDERATIONS

The previous section of this report identified the health care needs of Florida veterans over the next 30 years and the deficits in services which are expected. In making recommendations as to the course of action to pursue to meet the anticipated needs of future Florida veterans, the following points guided the analysis:

1. In light of high costs of construction and the long lead time required to approve design and build new facilities and the belief that better quality care is often given by non-institutional alternatives, non construction alternatives will be used to meet service needs to the extent possible. Such alternatives include the use of Geriatric Day Care Centers and Home Based Health Care.

2. Maximum size of VA nursing home care units in Florida is 240 beds because of quality of care and efficiency factors.

3. Colocation of nursing homes with satellite outpatient clinics is sufficient clinic support for 120 bed nursing home units.

4. New construction of general acute care beds will be located in an area of the state which has limited access to inpatient care; be of inexpensive construction which can still meet quality care; and be easily converted to nursing home beds. Any additional inpatient VA presence will be established in areas which have limited geographic access to existing facilities and the fastest growing veteran population.

5. These projections of health care needs are most accurate for 1990 and least accurate for 2010. However, all indications are that there will be a decrease in demand after the year 2000. The magnitude of the decrease will have to be studied further.

6. The need for medical care of veterans peaks in 2000. However, planning will be based on the needs between the years 1990 - 2000 in order to minimize excess capacity in 2000 and subsequent years.

7. The need that is considered most urgent is for extended psychiatric care. It is still felt that the true need for psychiatric care is not known and must be studied further.

8. Public Law 97-174 has mandated the VA and the Department of Defense to identify and assess opportunities for sharing of health care resources between the two agencies and to establish guidelines for such sharing.

STRATEGIC PLAN

A plan to meet the anticipated demands of the Florida veterans was developed based on the need for expansion and the considerations listed in the previous section. The elements of the plan indicated are those considered most appropriate based on the analysis of the projections currently considered most accurate. As projections are refined in future years, the plan elements for the planning horizon 2000 and 2010 will be updated and further developed. The cost estimates for the elements of the plan are 432.7 million dollars for construction and initial equipment and 242.6 million dollars for operating costs. This does not take into account the magnitude of savings that may be achieved through implementation of Public Law 97-174. A breakdown of cost figures for each element is shown in Table 7. These cost estimates have been made based upon current dollar costs of similar facilities and services.

Inpatient Hospital Beds

Elements:

1. Construct a 290 psychiatric bed facility to include 90 acute and 200 extended care psychiatry beds at VAMC Gainesville.

2. Convert space at an existing facility to accommodate 42 extended psychiatry beds at VAMC Miami.

3. Establish 1,000 additional hospital beds which may be in any configuration of size to meet the demand between 1990 and the peak demand in 2000 (see Table 3). The specific mix and level of care will be determined based on further study. Beds will be located in areas having the greatest veteran population and the least access to VA services. Placement of these beds should be based upon further study of veteran shifts in population (see Table 1), and may be located at either existing VA facilities or new sites.

Nursing Home Beds

The VA only meets a portion of the total need for nursing home care. Therefore, a market share of 14% has been applied to the total need. This census has historically been cared for with a program mix of 40% VA owned and operated beds, 40% community and 20% state home beds.

Elements:

4. Construct 800 VA operated beds in addition to current and planned beds. The end result will be 240 nursing home care beds at each existing VA medical center, and 120 nursing home care beds at satellite outpatient clinics at Orlando and Ft. Myers respectively and an additional 200 beds to be located based on the concepts listed under Considerations numbers 2 and 3, page 14.

5. Encourage the construction of a state nursing home to accommodate an average daily census of 570 patients. There is currently no state home in Florida. The VA may pay 65% of construction costs for a state home, if an application by the state is made and approved. The state is currently pursuing this option.

6. Contract for 1324 ADC in community nursing homes, an increase of 904 over current contract.

Outpatient Care

Elements:

7. Increase funding and ceiling for outpatient visits to meet a level of care which would be comparable to the national level of care. This would result in the need for approximately 364,400 additional outpatient visits.

8. Establish two outpatient clinics in areas which have limited geographic access to existing facilities and are the fastest growing areas, as well as establishing clinics at Pensacola and Daytona Beach.

Other

The following plan elements involve types of care which may impact the level of inpatient care needed in the future. This impact cannot be presently measured and therefore is not considered in the projected inpatient demand in Table I.

Elements:

9. Lease space or contract for the additional projected need for domiciliary beds. This care would take place in community facilities such as adult congregate living facilities.

10. Develop residential care programs to accommodate an ADC for 325 veterans by 1987.

11. Work jointly with community organizations to establish community-based and VA based Geriatric Day Care Centers* in five locations by 1986.

12. Increase provision of home health care services by the addition of a VA sponsored Hospital Based Home Care (HBHC) program at Tampa and greater utilization of existing HBHC programs and available community resources.

13. In view of Public Law 97-174, which is intended to promote sharing of health care resources between the VA and the Department of Defense, the VA should assess the capacity for such sharing in Florida. The VA should attempt to use any underutilized military facilities in Florida.

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*Geriatric Day Care Centers involves a form of care that includes medical, social and recreational activities on an outpatient basis.

TABLE 7
COST ESTIMATES
(in millions of dollars)

Plan Element	Additional Units	Construction & Equipment	Recurrin
1. Construction of Psychiatry Beds-Gainesville	290 beds	60.0	15.90
2. Conversion of Psychiatry Beds-Miami	42 beds	1.8	1.80
3. Construction of Hospital Beds	1,000 beds	233.5	100.00
4. Construction of Nursing Home Care Beds	800 beds	64.0	27.40
5. Contract State Home Nursing Home Care Beds	600 beds	28.8	2.50
6. Contract Community NHC	904 ADC		15.50
7. Expand Outpatient Ceilings	364,395 visits	35.0	32.00
8. Increase Outpatient Visits	480,000 visits	9.0	43.00
9. Contract Domiciliary Care	303 ADC		2.40
10. Develop Residential Care (referral inspection staff only)	325 ADC		.50
11. Work with Community to Establish GDCCs*	210 ADC		.40
11. Establish VA Operated GDCC's*	210 ADC	.6	1.10
12. Utilize Community HHC**	85 patients		.05
12. Expand and Establish Additional VA HBHC	90 patients		.08
		432.7	242.63

* Geriatric Day Care Center
** Home Health Care

APPENDIX A: GEORGIA COUNTIES INCLUDED IN MEDICAL DISTRICT 12

Atkinson
Bernen
Brantley
Brooks
Camden
Charlton
Clinch
Colquitt
Cook
Decatur
Echols
Grady
Lanier
Lowndes
Miller
Mitchell
Pierce
Thomas
Ware

APPENDIX B: VA/GAO BED-SIZING METHODOLOGY

1. Projected total bed requirements for a future year, by bed section, are determined by application of a time series analysis to historical utilization experience. The variables included consist of veteran population, admission rates, and lengths-of-stay, all on an age-specific basis.

2. The number and distribution of acute beds are determined by using length of stay data from the Professional Activity Study (PAS) of short-term non-federal hospitals, as compiled by the Commission on Professional and Hospital Activities. These lengths of stay are age and diagnosis specific and are adjusted to reflect the difference in the racial distribution between the PAS data base and the inpatients treated at the particular VA medical center. The adjusted PAS lengths of stay are used with the projected VA admisisons to obtain the projected acute-care bed requirements only.

3. The difference between total beds and acute beds constitutes "non-acute bed equivalents". These are distributed to the various non-acute levels of care, both hospital and non-hospital, on the basis of the results of the medical center's Multi-Level Care Survey, which is conducted to identify the level of care and type of facility needed by each inpatient as of the day of the survey.

4. Since the aforementioned methodology could not be applied to the eight-county Panhandle area in Medical District 10, the following assumptions were made:

   a. That the eight-county Panhandle area in Medical District 10 will experience the same bed visit rates per 1,000 veteran population as Medical District 10.

   b. That Medical District 10 bed visit rates per 1,000 veteran population in 1990 will remain constant throughout the planning horizon to 2010.

APPENDIX C: OUTPATIENT PROJECTION METHODOLOGY

1. The first step in the outpatient projection methodology determines visit rates by age group for four historical years.

2. These rates are then extrapolated into the future to obtain visit rates per 1000 veterans by age group. For this study the assumption was made that the visit rates would be constant from 1990-2010.

3. Projected visits for 1990, 2000, 2010 are computed by multiplying the projected visit rates by the projected veteran population for each of these years.

4. Since the aforementioned methodology could not be applied to the eight-county Panhandle area in Medical District 10, the following assumptions were made:

   a. That the eight-county Panhandle area in Medical District 10 will experience the same outpatient visit rates per 1,000 veteran population as Medical District 10.

   b. That Medical District 10 outpatient visit rates per 1,000 veteran population in 1990 will remain constant throughout the planning horizon to 2010.

5. Therefore for the Panhandle area, projected need for programs offered by the VA for 1990, 2000, and 2010 are computed by multiplying the projected outpatient visit rates by the projected veteran population of the eight-county area for each of these years.

APPENDIX D: NURSING HOME CARE NEEDS ASSESSMENT METHODOLOGY

The future nursing home care needs of veterans were assessed by applying an age-specific utilization rate, based on male civilian's use of nursing home care, to projected veteran population.

The civilian utilization rates were determined by extrapolating regional historical rates from the National Nursing Home Survey [1] into the future. The assumption was made for the purposes of this study that nursing home utilization rates would remain constant from 1990-2010.

The Veterans Administration will only meet a portion of the total need for nursing home care. Therefore, a market share (between 12% and 16%) is applied to the total need to obtain a census. This census is cared for in VA owned and operated beds as well as community and state beds. Historically this program mix has been 40% VA owned and operated, 40% community beds and 20% state beds. Allocation of the census will conform to this general historical precedent.

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[1] This survey is done by the National Center for Health Statistics.

APPENDIX E: DOMICILIARY BED PROJECTION METHODOLOGY

Several survey instruments were used to assess the current domiciliary need including surveys done at VA doms, VA medical centers and several studies done by the National Center for Health Statistics, such as the Health Interview Survey.

This current domiciliary need was divided by the current veteran population to determine a domiciliary need rate. This rate was multiplied by projected veteran population to obtain future needs for domiciliary beds.

As in the nursing home care program the VA will meet only a portion of this total need. Therefore, a market share (between 2.3% and 6%) is applied to the total need.

The American Legion
★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★
For God and Country

November 24, 1982

The Honorable Ron Mottl, Chairman
Subcommittee on Hospitals and Health Care
House Veterans Affairs Committee
2459 Rayburn House Office Building
Washington, D. C. 20515

ATTN: Mack Fleming

Dear Congressman Mottl:

Enclosed are two items relating to the VA Medical Center, Bronx, New York. One is a copy of a site visit report, of recent date, by an American Legion Field Representative. The other is copy of a special report by a Legion representative, in response to a specific complaint about food service at Bronx VAMC.

We are sure you will agree the enclosed material is hardly a reassuring advertisement for either the Veterans Administration or its Department of Medicine and Surgery.

We believe the Bronx VAMC is worthy of a Subcommittee or staff visit under your supervision, to see what can be done to improve conditions there, and to assign responsibility for expenditure of Congressionally appropriated funds. The American Legion will be glad to cooperate and assist in any action your Subcommittee undertakes in regard to Bronx VAMC.

Sincerely,

E. Lynch

R. E. LYNCH, Director
National Veterans Affairs and
Rehabilitation Commission

cc: The Honorable Robert Garcia
The Honorable Daniel P. Moynihan
The Honorable Alfonse D'Amato
E. Philip Riggin
W. F. Lenker
Mylio S. Kraja
Leonard Baxter

THE AMERICAN LEGION

NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
C/O VETERANS ADMINISTRATION
252 7TH AVENUE
NEW YORK, NEW YORK 10001

OFFICE OF REHABILITATION REPRESENTATIVE

TELEPHONE (212) 620-6316

NOV 10 1982

November 8, 1982

Mr. Robert E. Lyngh, Director
The American Legion
National Veterans Affairs &
Rehabilitation Commission
1608 K Street, N. W.
Washington, D. C. 20006

Dear Bob:

In accordance with your request I visited the Bronx Veterans Administration Medical Center on Thursday, November 4, 1982, and met with Dr. Wolf and Robbie Graham, Chief of Dietetics.

Miss Graham was aware of the situation on Wards 4-B and 4-C. Because of an arrangement of priorities, they are last to be fed. The situation is made worse by the lack and malfunction of equipment.

I was told that the dishes required by the hospital had been misplaced by G.S.A. and replacement dishes were not adequate to maintain the hot foods. I visited the kitchen and saw that all the dishes and pellets were in warmers and these warmers were not functioning properly and were in the process of being rewired by the Engineering Department. The dishes and pellets were only lukewarm when they should have been hot.

Also, the Cargo Master System has had problems. In one instance, the food cart was misplaced and lost and when finally located all the food was gone. It was probably eaten by the employees. It must have been good. Miss Graham had to return to the hospital at 9:00 P.M. that night and prepare a hot meal for those patients. In addidion, they do not have coffee cups and serve coffee in Styrofoam cups. They attempted to correct the situation by purchasing plastic thermos cups at 65¢ each. The first order of 700 cups only lasted two days. Only 200 cups remained. They made another purchase for replacement and when these disappeared they returned to the use of Styrofoam.

Central Office has agreed to purchase adequate China and cups and they expect a shipment, to their specifications, in the near future.

I also discussed the Out-Patient Clinic, especially E.N.T. of which Frank LaRocca complained. Dr. Wolf indicated that occasionally absenteeism caused back-ups in appointments especially in these special services.

In an aside, Frank told me that his complaint is primarily the refusal of the examining physician to order eyeglasses. He was advised it was not needed. He did go to the Out-Patient Clinic, New York Regional Office and was told the same thing.

I discussed this with Frank on Thursday night at the Treasury Post Dinner, and he was well satisfied.

Sincerely,

Herman Pheffer
Special Rehab. Representative

HP/ah

No. 2-027

NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
VISITATION REPORT
OF
VETERANS ADMINISTRATION MEDICAL CENTER
BRONX, NEW YORK
JUNE 28 - JULY 2, 1982

Date Received: July 22, 1982
Type of Medical Center: General Medical & Surgical
Spinal Cord Injury

LEONCE J. WILSON
National Field Representative
The American Legion
1608 K Street, N.W.
Washington, D.C. 20006

The American Legion FSR: No. 2-027

VETERANS ADMINISTRATION MEDICAL CENTER
BRONX, NEW YORK

I. INTRODUCTION

During the period of June 28 - July 2, 1982, a visitation of Veterans Administration Medical Center, Bronx, New York, was conducted to evaluate the quality, quantity, and timeliness of health care provided to veterans.

Coordination: Prior to this planned visit letters were forwarded to Dr. Julius Wolf, Hospital Director, and Messrs. Leonard E. Baxter, Department Adjutant; Douglas A. Wheat, Department Service Officer; Frank Wanamaker, The American Legion VAVS Representative, The American Legion, Department of New York, and Mr. Herman Pheffer, Special Rehabilitation Representative of The American Legion National Headquarters staff. I also met with Mr. W.J. Fuell, the Hospital Administration Specialist from the Veterans Administration Central Office. I was accompanied to the initial meeting with the Director and Acting Associate Director by Mr. Pheffer and Mr. Wheat.

Historical Background: This nine floor replacement hospital has been plagued with problems. Before the first shovel of dirt was turned, there were criticisms with some of the designed features. These complaints fell on deaf ears. Today there are approximately 1.7 million dollars worth of safety deficiencies built into the structure.

During the construction, problems abounded. Some of the let contracts were questionable. Materials and workmanship were not always up to standard. There were strikes. Equipment and supplies were often damaged or misappropriated. Subsequently, the completion date of the hospital was changed numerous times.

The delays in opening the hospital became a political embarrassment. Continuous pressure was applied to open the hospital. Although the building was not completed, it was opened in January, 1981. As of July, 1982, it still has not been completed. Some rooms have not been operational due to the lack of wiring and/or equipment not being installed. Four of the ten operating rooms were not functional during the survey.

The delays have been detrimental to the operation of the new equipment. Much of it was purchased early and sat around for one to two years before being installed. Breakdowns or complete failure of some equipment is common. A pneumatic tube system has never been operational and may never become properly operable. The contractor went bankrupt. Replacement contractors are unable to get it working. Homogenous parts may not have been used. Warranties covering much of the equipment have become a source of litigation. It may take years and countless sums of money to reach a conclusion.

The engineering staff has taken over some of the unfinished work. They are confronted with the task of rectifying the errors of others, while trying to maintain a building which continues to have major problems.

These problems, and others will be explained further in the body of the report. It must be mentioned that during the survey this writer did not feel he received the full cooperation of all the staff. After finding out that I had talked with someone from VACO prior to the visit, one employee wanted to know why I ever came to the hospital if I already knew what the problems were.

Statistical information pertaining to personnel strength, patients on the rolls and operating costs is attached.

Professional Affiliation: This Medical Center is affiliated with the Mount Sinai School of Medicine with fully integrated programs in surgery, medicine, and psychiatry. Affiliations also exist with the Cornell University Hospital for Special Surgery, the Brooklyn College of Pharmacy, the New York College of Podiatric Medicine, and Columbus University School of Dental and Oral Surgery. Approximately 147 residents rotate through the Medical Center each year.

Hospital Accreditation: The first survey of this new structure by the Joint Commission on Accreditation of Hospital (JCAH) is scheduled for this fall.

MISSION OF MEDICAL CENTER

The Mission of this Medical Center is to provide the highest quality of care to veterans. It is a 655 bed primary, secondary, and tertiary care facility which provides acute medical, surgical, psychiatric and spinal cord injury inpatient care, along with an 18 bed renal dialysis unit. A number of special treatment programs are provided in drugs, alcohol, and psychiatry. A large outpatient service is operational.

The beds are distributed as follows:

Medicine	237
Neurology	36
Spinal Cord Injury	80
Surgery	239
Psychiatry	63

The authorized beds are 702. It was reported that 47 of these beds were closed due to a low census. Some beds have never been operational because the wiring has not been installed or hooked up. One four bed room had to be converted into a gastroscopy room because one was not designed into the building.

II. OBSERVATIONS

Adequacy of Funds and Personnel to Permit Satisfactory Performance of the Assigned Mission: The Director stated that the FY 82 budget is adequate to finish out the year. The FY 83 budget will be sufficient as it stands.

The major staffing problems centers around nursing service. Absenteeism and traumatic injury abuse have been uncontrollable. Morale is very poor. The Chief of Nursing Sevice had to be relieved of duty. The resulting factor is the drop in the quality of care provided to veterans. Due to the lack of qualified nurses, the nine bed Surgical Intensive Care Unit (SICU) had to be closed down. (This was done without the approval of VACO.) The ten bed Medical Intensive Care Unit (MICU) has been split in half to provide beds for both medical and surgical patients. The recovery room is currently open 24 hours a day to help the workload in the MICU.

At first glance, space seems to be plentiful. After closer examination, usable space is found to be poor. Most of the patients rooms are fine, but office space is tight and storage areas are almost nonexistent. Some services have less space now than they had while in the old hospital. This will be discussed later in the report.

The emergency generators have been less than efficient. Since the hospital opened, there have been no less than four total blackouts. This has occurred during operating room procedures and dialysis treatments. The equipment is so sophisticated that even the suppliers are having a problem getting them to work properly. One generator has burned out and is being replaced. A generator from the old hospital is also supposed to be installed to add additional backup. Testing of the equipment is being conducted regularly to assure that each section of the hospital being connected to the generator is functioning properly.

The destruction of Building 13 and 26 has been a hotbed of controversy. Both are distant from the main complex and hard to keep secure. They both have become havens for vandals, thieves, and other undesirables. A decision was made to raze both buildings. Plans are being formulated to construct a new therapeutic pool closer to the hospital.

The construction of a Nursing Home Care Unit (NHCU) is scheduled for the near future. It is currently in the design phase. The same architectural engineer who designed the hospital is being used. It will be situated in front of the hospital, adjacent to the old chapel.

The acquisition of a Bloodmobile has been a real boon for this facility. It was provided by the Eastern Paralyzed Veterans Association. An arrangement with Fort Dix and McGuire Air Force Base in New Jersey has been beneficial to all three facilities. Periodically the mobile unit travels to those stations and draws blood. They are given what they need to operate their hospitals and the remainder is kept for the medical center.

Computerization of some areas of the hospital is being planned. The electrocardiogram computers were put on hold because VACO wanted to install equipment that is compatable with the Department of Defense Marquettee System.

Professional Services: The Acting Chief of Staff (COS) said that 78 of the 137 full and part-time physicians are board certified. Positions for a COS, a Chief of Spinal Cord Injury, and a part-time orthopedist are vacant. The COS position recently became vacant when the previous COS became the Hospital Director.

The 813 (education) funds were said to be deteriorating yearly, while educational requirements are increasing. Limited funds are provided to each individual. The Acting COS stated that the Northeast Region Medical Education Center (RMEC) located in Northport, New York has been very supportive.

The capability for Computerized Axial Tomography (CAT) Scans has been diminished. While the hospital was being constructed, the CAT Scanner went through two summers in an unairconditioned room. Since being installed, it has been down more than it has been working.

Another factor contributing to this downtime resulted from the lack of proper air-conditioning for the unit. The hospital air-conditioning could not keep the computer equipment cooled adequately. During the survey a separate cooling system was being installed. During this downtime, additional sophisticated capabilities were being integrated into the scanner.
The Chief of Radiology said he hoped the equipment would be operational by July 7, 1982. On July 19, 1982 it was still not in working condition due to a broken part.

Associate Director: The Associate Director was not available due to medical problems. He is off duty pending a disability retirement decision. The Chief of Dietetic Service has been the Acting Associate Director. On July 11, 1982, an Assistant Director is scheduled to arrive.

The Acting Associate Director stated that the services under her realm were operating effectively. Security Service has been under many pressures. This service will be expounded upon later in the report.

The local fire department provides protection for this facility. Relationships with them have deteriorated due to the number of false alarms activated by malfunctioning smoke detectors. There have been as many as 5-6 during a one week period.

Laundry service is provided by VAMC Manhattan. No major problems were voiced. Studies are being conducted to examine the feasibilty of having it done at VAMC Brooklyn, St. Albans Division.

Security Service has a total FTE of 43. This includes two locksmiths. The Chief said they are attempting to obtain control of all the locks in the hospital. During the survey, there were eight vacancies and four temporary positions. Four of the current staff may be leaving for better paying jobs.

There are a number of reasons that officers are hard to recruit and retain. Money is a big factor. The officers have to provide the same service as the New York City Police, but are not allowed to carry weapons. A week before the survey, a call was received that intruders were seen in one of the out buildings. When security arrived, one of the suspects drew a revolver. Fortunately, the intruder left while holding the officers at gunpoint. This is not an isolated incident. A proposal has gone to the Office of Personnel Management (OPM) for a pay increase. An answer has not yet been received.

Another problem lies with the registers provided by OPM. The one register received at this facility had an undesirable person at the top of the list. No one in the New York City area wanted this person, therefore, all the other candidates were frozen until the name could be removed. It seems that the screening procedures for the OPM register are very inadequate.

Problems are not resolved by either the Federal Bureau of Investigation (FBI) or the United States Attorney's Office. The FBI has sole jurisdiction at the Bronx, but they do not want to get involved in anything they consider petty. Their response is "Just send us a report". The New York City police have been more than cooperative. They had been coming in to make arrests, but when the District Attorney found out about it, he stopped prosecuting the intruders.

The U.S. Attorney has been of little help. Rather than prosecute, he said to just issue a citation when someone is caught. The Chief said some of the culprits have 6-8 citations. Many use aliases.

All these actions, or inactions, have made it very frustrating for security to effectively carry out their duties. The Chief tries to keep them motivated, but the service seems to be fighting a losing battle.

In February 1982, a metal detector was installed at the main entrance to the hospital. This was prompted by an unfortunate incident in which two employees were shot. All other doors have been electronically locked for entering and exiting the hospital. Prior to its installation only 31 weapons were confiscated in a two year period. During the first month of operation, 141 weapons were confiscated. In March, April, and May, there were 228, 83, and 80 weapons taken. Two security personnel are usually assigned to the main entrance. Through numerous observations, the use of the metal detector was anywhere from tight to haphazard. Sometimes people were screened carefully. Other times the bags, et. al. they carried were not checked, even if they set off the hand scanner. (The scanner is used on paraphernalia placed on a table next to the metal detector.) One time, during a heavy flow of visitors, some people were observed going through the detector before the wait light went off.

Security Service does not have entire control of the grounds because of the construction and demolition crews still working there. They have their own security, but hospital security provides radios and backup when necessary. One night, after failing to reach a construction security officer on the radio, they investigated and found him asleep. In another incident, it was noted that another of the construction security officers was turning his back while thieves were making off with government property from one of the out buildings. In FY 81 the theft of government property amounted to $66,420. Approximately $18,000 worth had been taken as of April, 1982.

A closed circuit TV system has been approved and funded. An emergency alarm system is also to be installed.

REGIONALIZATION

This Medical Center is in Medical District 3 of the Northeastern Region. The Director said his facility was receiving its fair share, but that a better way of paying them for services provided to other VA hospitals was needed.

ORIENTATION/PREPARATION OF INCOMING PERSONNEL

Phase I consists of the employee's initial interview with Personnel Service where his salary, benefits, etc. are explained. Phase II is at the job site with the employee's immediate supervisor. Phase III is the monthly orientation to the hospital and services. This is operated by Personnel Service and consists of speakers from different areas of the hospital.

Traumatic Injury abuse is an ongoing, difficult problem. The 45 days off for an injury has become a disasterous program. Nursing Service reported that at any one time there are approximately 15 employees off. Nine were reported off from the Surgical Intensive Care Unit. It was reported that some physicians in the community would sign anything for a price.

ADMISSION, OUTPATIENT CLINIC AND AMBULATORY CARE SERVICE

One part-time position for a physician is the only vacancy in this service. Recruitment is in progress to fill it.

The number of outpatient visits had been on the decline due to adverse publicity. About ten months ago a local TV reporter infiltrated as a VAVS volunteer. Her slanted reporting took incidents out of context to portray the hospital as giving improper care. The accumulated outpatient visits through the end of June were 108,821.

An Admission Processing Time Study was conducted on March 31, 1982. One hundred six (106) participants were involved in the 24 hour survey. The overall average processing and waiting time was 2 hours and 36 minutes.

The Chief of this service said there were many security problems until the metal detector was installed. The doors to this area are all locked, but can be opened by security whenever necessary. One security officer is on duty in this area at all times. He has a hand scanner that is used when emergency admissions arrive.

Medical Administration Service: Vacancies for a teletypist, 2 keypunch operators, and a telephone operator were being recruited.

Centralized scheduling is used only for the clinics. It is manually operated, but plans are being made for computerization of this service. A timetable has not been established.

Four veteran employees have been billed for medical treatment received at this facility. Two still are employed, one transferred, and one died. No payment has been made, to date. Appeals are pending.

The bed utilization for the month of May is as follows: Number of beds (NOB); Average Daily Census(ADC); Occupancy Rate(OCC).

	NOB	ADC	OCC
Medicine	237	182	76.8
Neurology	36	33	91.7
SCI	80	68	85.0
Surgery	239	177	74.1
Psychiatry	63	60	95.2
Total Hospital	655	520	79.4

On July 1, 1982, the in-house breakdown of service-connected (SC) and nonservice-connected (NSC) by bed service was:

	SC	NSC
Medicine	44	137
Respiratory Care	4	18
Surgery	35	99
Psychiatry	13	25
Alcohol Treatment	0	16
Spinal Cord Injury	6	55

The acceptance rate of Applications for Medical Care (VA Form 10-10) is 77%. The Director said this rate is too low due to errors in recording. He said that veterans put on outpatient treatment had been counted as being rejected.

BED SERVICES

Medical Service has 273 authorized beds, but only 237 operating beds. Thirty-six beds are closed for various reasons. Some are closed because of the low census. Others are closed because the wiring has not been hooked up. Still others are out because the rooms had to be converted to needed treatment areas not designed into the hospital.

The MICU on the eighth floor is being used for medical and surgical intensive care patients. The Chief of Medicine said that it is terrible that ICU beds have to be closed in this day and age. He stated that there has been no cross contamination yet. Unfortunately some veterans have to be transferred to the understaffed wards before they are ready. This is not good medical treatment, but decisions have to be made daily regarding who needs the intensive treatment most.

The Dialysis Unit is located on the ninth floor. Attempts to have this inane site changed while still in the design phase were unsuccessful. Getting the proper water pressure to the top floor has been a major concern. If this unit ever goes out of service for 2-3 days, there is no place in New York City that would be able to handle the extra workload. An alternate pumping system is going out for bids. When installed, this should provide adequate water pressure to this treatment area.

The Chief said equipment for this area is very good, but all of it has not been installed. The equipment for the cardiac step-down unit has been on station for 16 months. The electrical contractor defaulted on connecting the wiring to the rooms. The Engineering Service is in the process of doing this work.

A room for computerized electrocardiograph (EKG) equipment is empty. The computer is capable of reading EKGs and giving printouts of the interpretations. VACO made changes in the equipment specifications that will be compatable with the Department of Defense computers. No date for its installation has been set.

Patient space is described as adequate. Office space is tight. Storage is impossible to locate.

Surgical Service consists of 239 operating beds. Seven beds are closed for the reasons mentioned under the Medical Service. The 10 bed SICU located on the fourth floor is also closed. This is due to a nursing problem. It was reported that nine nurses from this area are out due to traumatic injury. This is only to be a temporary closure while additional nurses are being trained. It has been closed approximately one month.

The Chief of Surgery said the SICU closure has delayed some major operations and caused some patient distress. To date there have been no life threatening situations, but many of these veterans have multi-system problems. The recovery room beds are opened 24 hours a day to help disperse the workload of the ICU.

The surgical suite consists of 10 operating rooms, (ORs) but only six are functional. The other four have not been completed yet. The two cystoscopy rooms need the final finishing completed and the large ORs have some electrical problems.

Since the hospital opened, there have been four total blackouts. The longest was 10-15 minutes. These occurred during OR procedures. The Chief said that only luck prevented any serious incidents. The repair and replacement of the faulty emergency generators should eliminate this occurrence.

The air in the OR has been a major concern. The air intake valve for this area is located near the loading dock. The truck exhaust fumes are being drawn into the ORs. When VACO was asked what could be done to eliminate this design flaw, their reply was to have the truck drivers turn off their engines.

The unbalanced air-conditioning has been a problem throughout the hospital. The Chief of Surgery said that the ORs have gotten up to 90 degrees at times. The Director disagreed with the 90 degree mark, but said there has been a big fluctuation in temperatures. Humidity control is also a problem. The Director stated that the design of the Heating, and Air Conditioning (HVAC) System needs to be changed before it will operate efficiently.

The SICU and ORs are separated by two floors. Before construction started, it was suggested that the two areas be located on the same floor. This suggestion went unheeded.

Ward space is good, but office space is less than ideal. Storage space is virtually nonexistent.

Psychiatry Service is assigned 63 beds. Twenty are for alcohol treatment and will be discussed later in the report. Twenty-two beds are from an admitting unit, 13 beds for acute psychiatry, and 8 beds for a 30 day drug detoxification program. After being detoxed, these veterans are followed as outpatients. Currently, 150 veterans are being followed. Eighty-five percent are employed.

The Assistant Chief said that some NSC veterans have to be referred to the community or sent to Montrose. Additional beds would have to be provided to this service to eliminate this.

The establishment of Geriatric Research, Education, and Clinical Center (GRECC) is in the planning stages. A representative from VACO was visiting with the Chief of Psychiatry during the survey to discuss the matter.

Alcohol Dependence Treatment Program (ADTP): The ADTP consists of the following staff:

1 Director
1 Chief-Inpatient Rehab Section

1	Chief-Outpatient Rehab Section
1	Chief-Medical Section
2	Psychologists
8	Registered Nurses
3	Social Workers
1	Fellow
1	Social Science Analyst
1	Mental Health Associate
1	Technician
1	Research Coordinator
1	Secretary
1	Internist (part-time)
1	Dietician (part-time)

One employee is a recovering alcoholic.

This 20 bed ADTP was established in 1977 and provided special funding in 1978. The length of the inpatient program is four weeks. Prior to admission, a patient has to be alcohol free. Detoxification is administered by the Medical Service.

A multi-disciplinary team approach is used to treat the patients. The intense treatment program consists of individual and group therapy, AA meetings and educational, vocational, and occupational therapies. Antabuse is encouraged, but not mandatory. During their treatment, the veterans are not allowed to leave the hospital on pass, except in dire emergencies.

The outpatient follow-up provides treatment for medical conditions related to alcoholism, as well as continued rehabilitation. Usually, 300-400 veterans are on the rolls. At least one year of follow-up is advised.

Extensive research concerning the varing effects of alcohol on the body is in progress. The funding is provided by the National Institute on Alcohol Abuse and Alcoholism, and administered by the Mount Sinai School of Medicine.

The main problem the Chief said that they have to overcome is the receipt of adequate support and recognition as a health treatment program.

Spinal Cord Injury Unit (SICU) has an 80 bed allocation. Forty are acute beds and 40 are long term beds. The length of stay on the acute unit ranges from six months to one year. The long term unit averages eight years. Two patients have been here since 1945.

Core staffing was said to be good. Support personnel has been deteriorating. Morale is poor and burnout is high. The yearly turnover rate is between 20% and 25%. In May, 1982, five staff left because of traumatic injuries, four transferred out, and one left on emergency leave. Some of these positions cannot be filled because the staff are still assigned to the SCIU. The majority of these employees are from Nursing Service.

The urology clinic located in the SICU is not yet in operation. There have been a number of problems with functioning of the new radiology equipment. It is theorized that it will be operational by the end of July, 1982. Skepticism teems.

Insulation in the hospital is inadequate. A number of areas could not be kept warm last winter. One four-bedroom on this unit had to be closed last winter. This summer a contractor is supposed to upgrade all the affected areas. As of July 22, 1982, nothing had been done.

There are plans to activate 20 additional long term beds. They could be readily filled, but better stabilization of the staff is necessary first. Harmony has not been the state of the art on this unit. It was reported that the Chief of the SCIU has met many roadblocks while trying to stabilize his service. His enthusiasm has ebbed. Recruitment of a new Chief is in progress. One candidate decided not to come. If he had come, three additional physician positions would have been provided. Each year at least one additional doctor has been requested without success. Three of the five doctors are assigned to the 80 beds. The other two are assigned to the OPT care and the Hospital Based Home Care (HBHC)programs. Currently, there are 335 veterans receiving OPT treatment and 19 in the HBHC.

A therapeutic pool would be very beneficial for this service. The present pool has been closed because of extensive vandalism and its inaccessability due to demolition of the old hospital. The cost of repairing this pool is beyond reason. A replacement pool closer to the new hospital would be more realistic. If constructed near the new NHCU, it would be accessible by many more patients and be easier to secure from intruders.

Rehabilitation Medicine Service (RMS) is poorly designed. At present there are 20 operating beds located on two ward areas. Total space is very inadequate. The Educational Therapy and Vocational Rehab Therapy Clinics are located in rooms averaging 10' by 13'. These cracker boxes are extremely inadequate for wheelchair and stretcher patients. The Director said that when the old chapel is refurbished, the inhouse chapel will be used to expand RMS and the pharmacy. This will not occur for a year or more.

Equipment is very good, but not all of it is hooked up. Some areas do not have the correct voltage wired in. Some outlets had to be disconnected because they were fire hazards. One area is the occupational therapy (OT) clinic. For some obscure reason, recessed floor outlets were placed in this clinic. When Building Management washed the floors, it was discovered that these outlets were not waterproof. They have been disconnected and coverplates placed over them, but the concaved areas are still present. This is a potential safety hazard for patients that needs to be corrected.

Some space in the OT clinic has to be utilized as a doctor's evaluation room because no space was designed for one. The five cubicles are separated from the clinic by curtains and storage cabinets. The noise contamination and the shortage of appropriate washing facilities makes this setup less than adequate.

Besides the therapies already mentioned, this service also provides physical therapy, occupational therapy, and driver training. Two automobiles and a van are available. Two simulators cannot be used until room is available. Their deployment is scheduled for early October.

Vacancies exist for two occupational therapists, two physical therapists, and a corrective therapist. Two additional physical therapist positions may become vacant in August. Recruitment for all positions is in progress.

MEDICAL SUPPORTIVE SERVICES

Pharmacy Service has approximately one half of the required space needed to function efficiently. Its unsuitable location is between the only hospital entrance/exit and the Canteen Service. The congestion outside the Pharmacy is constant. The outpatient (OPT) waiting area is the hallway. A representative from VACO suggested that the OPT area be redesigned to improve the traffic flow.

Satellite pharmacies exist on each floor, but are not operational due to the limited staffing. The Chief said he could use 3-4 additional pharmacy technicians.

Patient consultations are limited. The Chief said there just was not enough time to provide this service on a regular basis. The OPT consult room was eliminated to increase what little waiting area there was.

The number of OPT prescriptions filled at the window each week is 7,000. The turnaround time ranges from 15-30 minutes for SC veterans to 1-3 hours for NSC veterans. Some of the workload will be reduced when medication for the diabetic patient is dispensed at the clinic.

Between 800 and 900 mailouts are registered each week with a turnaround time of four days. All mailouts have to be sent by certified mail because of the areas the veterans live in.

One hundred thirty-five patients are on the methadone maintenance program. Nine hundred eighty doses are given weekly.

A number of design flaws faced this service when it first opened, but many have been corrected. One security problem that still needs correcting is the lack of floor to ceiling walls in one area. The outside wall only runs from the floor to the false ceiling.

Security alarms have not been installed. They are still in the planning phase.

Nursing Service has been riddled with morale problems. This has greatly affected its functioning and the quality of patient care. There have been many internal problems, starting at the top. The Chief had to be relieved of duty due to personal problems. Recruitment is in progress for a new one. The Acting Chief is attempting to stablize the service, but it has been a slow process.

Traumatic injury and absenteeism are rampant. At any time there are approximately 15 employees out with TI. Some are out with their second injury. Absentees range between 15 and 25 daily, depending on the weather. In January, February, and April of this year the call ins were 900, 600, and 800, respectively. This type of situation puts a burden on the dedicated staff and, in turn, the veterans. It is uncommon for one unit to be cannibalized to provide coverage for another. Sometimes a unit has to be left uncovered because there is not enough staff to go around.

Social Work Service has three vacancies, and will have a fourth in July when one social worker retires. The Chief said it is a lengthy and tedious process to fill these positions. A register from OPM was requested on June 1, 1982, but as of July 1, 1982 he had not received an answer.

There are three contract nursing homes in the service area of this facility. Established homes in other medical center areas are also used. There were forty placements during the survey.

A small Residential Home Care Program is operational. There are six placements.

One social worker is assigned to the HBHC program. It was established ten years ago. A maximum of 22 placements can be handled. The length of the program varies with each patient. Turnover has been good. Most of the SCI patients are seen at least twice a month.

ANCILLARY SERVICES

Dietetic Service has been bothered by some absenteeism. Most of it occurs on weekends and after paydays. Five part-time positions were vacant during the survey. Recruitment was in progress.

The raw ration cost for the second quarter of FY 82 was $3.63. During April, an average of 531 rations were served daily. All patients are served at their beds. The Pellet system is used.

Automated carts are used to transport the meals to the units. The carts are placed on a track. A metal arm slides out from a miniature elevator. When it reaches the cart, a prong is inserted into the cart bottom and it is pulled onto the elevator. It is then computer programed to go to a designated floor. There, the reverse process is supposed to occur. For various reasons, the prong does not always release the cart. It is then pulled back into the elevator and dropped off in some other area. The staff then has to hunt for the carts. Other services also use this system.

Much of the equipment for this service was purchased in 1977-78 and sat unused for four years. Some of it has not been working regularly. The most frequent breakdowns occur with the dishwashing, pots and pans washing machines. There were two incidents of breakdowns during the week of the survey. It was reported that the equipment is not the best quality and that the contractor installing it went bankrupt. While it sat, the warranties elapsed.

The freezers are working now, but when the move to the new building first occurred, the food had to be kept in the old hospital. Although functioning, they are leaking. A large buildup of ice was noted inside the door. This occurrence is also evident in the Canteen Service freezers. Many complaints have been registered to the contractor.

Overall space is good except for non-food storage. Paper products are piled everywhere a space exists.

Veterans Administration Voluntary Service (VAVS) consists of 35 organizations. The 455* regularly scheduled (RS) volunteers contributed 58,500 hours for the first half of FY 82.

The American Legion Representative is Mr. Frank Wanamaker. A new deputy was being recruited. From October, 1981 through May, 1982 the 28* RS volunteers contributed 11,624 hours.

For the same period, the 14* RS American Legion Auxiliary volunteers contributed 2,383 hours. Their representative is Mrs. Amanda Meyenberg. Her deputy is Mrs. Mary Neill.

(*Due to computer problems, only approximate RS volunteer numbers were available.)

A summer youth program is being established. It should be operational within a year.

Five area schools participate in a credit program. Each year 75-80 handicapped students participate. They are accompanied by an instructor. This has been occurring for about 18 years and has been very beneficial to the hospital and the students.

As mentioned earlier, reporters from a local TV station infiltrated this service to gather and slant information regarding care given by VA hospitals. It is speculated that the purpose was to show why veterans should be mainstreamed into the private sector.

Recreation Service has been on its own for a year and a half. Prior to this, it was a section under VAVS.

Coverage for activities is provided until 9 p.m. Monday through Saturday. Sundays activities are handled by VAVS volunteers.

Off-station trips are scheduled 2-3 times a week. They are usually geared for the SCI patients. On station activities include barbecues, movies, bingo, and free phone calls provided by one of the VAVS organizations.

The biggest problem is locating space not being used by others. Conference rooms are currently being scheduled for activities.

III. CONCLUSIONS

The quality and quantity of care provided to veterans at this Medical Center needs to be improved. Many factors prohibiting good care have been outlined in the report. They are only the tip of the iceberg. A number of surveys have been done prior to this that outline the exact problem areas. Many have been, or are in the process of being, corrected.

The fact that this building was occupied before it was completed is inane. The fact that people were forced to move in, because the delayed openings were an embarrassment to someone, is no less than scandalous. The staff has been subjected to unfair criticism for events beyond their control. As problems arise, they try to get them repaired, but they are outnumbered. Much of the equipment had never been tested.

The people who suffer most because of numerous deficiencies are the sick and injured. As a veteran, I would not desire to be subjected to this while being ill. To cite some of the problems: diagnostic failures, rooms with poor insulation, unbalanced HVAC, incomplete wiring, etc., just to name some of the many problems.

Safety deficiencies designed into this building total approximately $1.7 million dollars. It was reported that the architectural engineer who designed this building was awarded a prize by his colleagues. It must have been only for esthetics and not for the practical functionability of a hospital. A statement made in a 1981 report sums it up best. "VAMC Bronx is a new building, yet it has deficiencies which occur in many of our older facilities."

A new Nursing Home Care Unit is being designed for this facility. It is direly needed to handle the many aging veterans waiting to get into nursing homes.

A new therapeutic pool is needed for this facility. The old pool is no longer usable. It has been vandalized beyond reasonable repair. New pool construction will be closer to the new hospital and would be more beneficial to everyone.

Nursing Service is in a state of flux. Morale is ebbing. Pressure is placed on many of the dedicated staff to fill in for the employees who make a living at being absent. The SICU had to be closed due to a lack of qualified nurses. Reports of 9 SICU staff being out with traumatic injury are astounding. About 200 nurse applications are on file in Personnel, but they are useless until the deadwood can be eliminated.

Many problems were mentioned regarding the OPM registers. They ranged from delays in receiving the registers to having unqualified people listed. Trying to fill positions has been a tedious process.

IV. RECOMMENDATIONS

Background data and assessment on each of the following recommendations for this VA health care facility will be found in the observations and conclusions sections of this visitation report.

1. The American Legion recommends that VACO provide full support in correcting the many deficiencies at this facility.

2. The American Legion recommends that VACO scrutinize the design and construction of the new Nursing Home Care Unit to eliminate the problems that befell the new hospital.

3. The American Legion recommends the construction of a new therapeutic pool adjacent to the new hospital and NHCU.

4. The American Legion recommends that VACO assist this facility in receiving usable OPM registers in a timely manner.

**STAFF

TOTAL MEDICAL CENTER PERSONNEL (FTE) 1918

CORE RATIO 2.2

STAFF PHYSICIANS (FTE) 115.6

CONSULTANTS ON THE ROLLS 163

ATTENDINGS ON THE ROLLS 104

RESIDENTS 284

MEDICAL STUDENTS 50

PHYSICIAN EXTENDERS N/A

MAJOR PERSONNEL SHORTAGES

PHYSICIANS (FT BY SPECIALTY) Spinal Cord Injury, Orthopedics

REGISTERED NURSES 20-30

LICENSED PRACTICAL NURSES -

NURSING ASSISTANTS -

OTHERS -

SCHEDULED FOR ADMISSION (SERVICE-CONNECTED) 2

SCHEDULED FOR ADMISSION (NONSERVICE-CONNECTED) 11

SUMMARIES PENDING 76

TOTAL NUMBER OF REQUESTS FOR DISABILITY EVALUATION EXAMINATIONS (2507) ON HAND WHICH HAVE NOT BEEN COMPLETED AND RETURNED TO VA REGIONAL OFFICE 1

OPERATING BEDS IN NURSING HOME CARE UNITS N/A

FUNDS

AVERAGE COST PER PATIENT DAY $272.00

AVERAGE COST PER OUTPATIENT VISIT $45.00

AVERAGE COST PER NHCU DAY 0

AVERAGE COST PER PATIENT DAY IN COMMUNITY NURSING HOMES $82.00

MEDICAL CENTER BUDGET ALLOCATION (THIS FISCAL YEAR) $67,297,532.00

MEDICAL CENTER BUDGET ALLOCATION (LAST FISCAL YEAR) $66,637,055.00

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

LOCATION Bronx VA Medical Center DATE OF INFORMATION 6/23/82

MEDICAL CENTER DIRECTOR Julius Wolf, M.D.

ASSOCIATE
~~ASSISTANT~~ MEDICAL CENTER DIRECTOR (Acting) Robbie E. Graham

CHIEF OF STAFF Courtney B. Wood, M.D. (Acting)

MEDICAL SCHOOL AFFILIATION Mt. Sinai Medical Center

	CURRENT FY 1982	LAST FY 1981
BED CAPACITY	702	702
OPERATING BEDS	655	655
AVERAGE DAILY		
(To date) INPATIENT CENSUS	520	517
(To date) OUTPATIENT VISIT (ACCUM.)	100,536	138,631
WAITING LIST:		
SERVICE-CONNECTED	* N/A	* N/A
NONSERVICE-CONNECTED	* N/A	* N/A

EXPLAIN THE REASON FOR THE WAITING LIST:

* N/A

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

RECEIVED LAST FISCAL YEAR 33,139

NUMBER OF APPLICATIONS ACCEPTED 25,081

NUMBER OF APPLICATIONS REJECTED 8,058

**APPLICATIONS FOR MEDICAL CARE RECEIVED THIS FISCAL YEAR 19,613

NUMBER OF APPLICATIONS ACCEPTED 15,136

NUMBER OF APPLICATIONS REJECTED 4,477

* N/A (Non-applicable)
** All Fiscal Year 82 information as of May 1982

December 15, 1982

Honorable Everett Alvarez, Jr.
Deputy Administrator
Veterans Administration
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Everett:

As indicated by the Chairman of the Subcommittee on Hospitals and Health Care, the Honorable Ronald Mottl, I desire that certain questions listed below be answered. The questions and answers will appear in the printed record of the hearing held before the House Veterans Affairs Committee on Tuesday, December 14.

1. On page 4 of your testimony, you indicate that VA has formulated new construction plans and methodology to assess actual conditions and needs of VA medical facilities. How did you make decisions before and doesn't the fact that you recently revalidated most of your 1984 plans indicate that you previously had a pretty good system?
2. Each year this Committee gets the VA's various lists of priority construction projects. Sometimes they are changed. Is your present review process going to assure a project's orderly progress up the priority list with a better degree of predictability?
3. Has the Office of Management and Budget ordered the VA to downsize the Minneapolis VA Hospital by 200 beds? If so, what action has the VA taken in response to that directive?
4. Why has the cost of constructing nursing beds gone up so dramatically as compared to the private sector and do youhhave plans to reduce your costs?
5. What is the status of the two projects in Little Rock?
6. I understand that the North Little Rock Hospital is nearing completion but that upon that completion Central Office is ordering $250,000 worth of new safety windows to be installed and that the local construction people question the need for this expenditure. Would you please clarify this for the record?

Sincerely,

JOHN PAUL HAMMERSCHMIDT
Member of Congress

VETERANS ADMINISTRATION
1930

The Deputy Administrator
of Veterans Affairs
Washington, D.C. 20420

FEBRUARY 15 1983

Honorable John Paul Hammerschmidt
House of Representatives
Washington, D. C. 20515

Dear Mr. Hammerschmidt:

Thank you for your letter of December 15, 1982, concerning questions raised during the hearing held before the House Veterans' Affairs Committee on Tuesday, December 14, 1982. The enclosed responses to each question are submitted for inclusion into the printed record of that hearing.

Your interest in this matter is appreciated.

Sincerely,

Everett Alvarez Jr.

EVERETT ALVAREZ, JR.
Deputy Administrator

Enclosure

Question 1: On page four of your testimony, you indicate that VA has formulated new construction plans and methodology to assess actual conditions and needs of VA medical facilities. How did you make decisions before and doesn't the fact that you recently revalidated most of your 1984 plans indicate that you previously had a pretty good system?

Answer: The reference to new methodologies relates to an initiative VA expects to undertake in FY 1984. Specifically, VA intends to undertake a thorough technical assessment of all VA medical facilities for the purpose of establishing an information base which, when merged with results of the MEDIPP program plans, will form the foundation for future construction planning. This is a new initiative in that it will be the first time the VA has attempted a centrally directed technical (or physical) assessment of all its medical facilities at one time. Technical assessments were conducted in the past on a project-by-project basis, as development of each project began; or for specific technical program areas such as electrical or fire safety. Therefore, it was not surprising that the FY 1984 special review essentially "revalidated" ongoing construction planning.

While the results of the revalidation process point to the conclusion that our existing system is effective, it is the VA's intention to improve upon the existing methodology. It is believed that this comprehensive technical assessment of the VA medical facilities will be a significant step in that direction.

Question 2: Each year this Committee gets the VA's various lists of priority construction projects. Sometimes they are changed. Is your present review process going to assure a project's orderly progress up the priority list with a better degree of predictability?

Answer: With the exceptions of the addition of three Medical Centers (Biloxi, Gainesville, Baltimore Area) to the VA's "List of Medical Centers Most in Need of Construction, Replacement or Major Modernization" ("List of Ten") and the deletion of three funded projects (New Orleans, Tucson and Palo Alto), the "List of Ten" and their relative priority have remained unchanged since the first Medical Facility Construction Plan was submitted to Congress in August 1979. The three "new" projects were added to the bottom of the list as positions became open due to the funding of projects. The various elements of the planning and design process, along with other unforeseeable contingencies, cause these very large projects to follow varying time frames as they move toward a position where the VA is ready to request construction funding. Factors such as development of demographic packages and needs assessments, concepts to be chosen from, design of preliminary drawings, cost estimates and funding availability in a limited budgetary resource milieu do not follow a set course for each project. Therefore, projects such as Minneapolis and Houston, which have held the number 1 and 2 positions on the "List of Ten" since the FY 1980-FY 1985 Medical Facility Construction Plan, have not been the first and second projects proposed for construction funding.

Although the recently implemented MEDIPP process and other VA planning initiatives should strengthen the VA's ability to assess relative needs, the actual accomplishment of each individual project will continue to be affected by the above mentioned factors.

Question 3: Has the Office of Management and Budget ordered the VA to downsize the Minneapolis VA Hospital by 200 beds? If so, what action has the VA taken in response to that directive?

Answer: Although the number of beds to be built in Minneapolis was a consideration in our budget negotiations with OMB for fiscal year 1984, the Administration has not reduced the planned size of the replacement hospital. The project will continue to be developed for 725 hospital and 120 nursing home care beds.

Question 4: Why has the cost of constructing nursing beds gone up so dramatically as compared to the private sector and do you have plans to reduce your costs?

Answer: A task force, comprised of program officials from the Department of Medicine and Surgery and the Office of Construction, has been working, since November 1981, on an effort to identify areas in which the cost of new construction for VA Nursing Home Care Units (NHCUs) can be reduced. The Task Force identified several significant areas that contributed to the wide difference in construction costs between a private sector NHCU and the VA's NHCU. Some of these identified areas are:

1) The VA NHCUs serve more chronically ill patients than does the private sector on the whole. Building-in of support services for these sicker patients contributes to higher construction costs.

2) The VA places a greater emphasis on life cycle costs rather than first costs of construction. The VA NHCU is built to last longer than the comparable private sector NHCU.

3) The VA policy to build new NHCUs only on existing VA medical center sites frequently contributes to higher costs due to necessary modifications made to make the site suitable for construction.

4) Federal contract requirements contain social and other legislated provisions which cause higher costs (e.g. Davis-Bacon Act).

5) VA cost estimates project a future year cost which includes costs for technical services, contingencies, SBA allowance and inflation. Private sector costs are quoted from the actual bid price of the project which does not encompass the other costs included in the VA estimate. A comparison between the private sector costs and VA costs is therefore misleading.

The efforts of the Task Force, thus far, have concentrated on the areas of identifying program space needs and validating established VA construction criteria. Although the work of the Task Force is still ongoing, there have been reductions incorporated into planning and design that will result in a projected cost reduction of between 1.5 and 2 million dollars for a 120-bed Nursing Home Care Unit.

Question 5: What is the status of the two projects in Little Rock?

Answer: 1,000 Bed Renovation - North Little Rock Division

Project Status:

1) POD II Construction accepted by VA on October 22, 1982, Activation - November 1982

2) POD I Construction - expected completion date in January 1983.

3) Estimated completion date of entire project in June 1983

505 Bed Replacement Hospital - Little Rock Division

Project Status:

1) Project is 70% completed. Expected construction completion date in September 1983.

Testimony by:
SENATOR RUDY BOSCHWITZ

THANK YOU FOR THIS OPPORTUNITY TO COMMENT ON THE VETERANS ADMINISTRATION MEDICAL FACILITIES PROGRAM.

THE VETERANS MEDICAL CARE SYSTEM IS OFTEN MISUNDERSTOOD, AND BECAUSE OF THIS MISUNDERSTANDING, PEOPLE OFTEN OPPOSE CONSTRUCTION OF REPLACEMENT VETERANS HOSPITALS WHEN LOCAL HOSPITALS HAVE AVAILABLE BEDS. THE REPLACEMENT HOSPITAL PLANNED FOR MINNEAPOLIS IS NO EXCEPTION.

AS YOU KNOW, VETERANS ARE ADMITTED TO VETERANS HOSPITALS IN ORDER OF PRIORITY ON A SPACE-AVAILABLE BASIS: FIRST, SERVICE CONNECTED VETERANS; SECOND VETS OVER AGE 65; THIRD, FORMER POWS; FOURTH, NON-SERVICE CONNECTED VETERANS. THE HOSPITAL IN MINNEAPOLIS CURRENTLY HAS 55 PERCENT OF ITS PATIENTS IN THE OVER 65 CATEGORY. THIS POPULATION GROUP WILL INCREASE BY 40 PERCENT IN THE NEXT DECADE.

THESE VETERANS WILL NEED BOTH QUALITY MEDICAL CARE AND QUALITY NURSING HOME CARE. I, AND MOST OF THE MINNESOTA DELEGATION, HAVE BEEN FIGHTING FOR SEVERAL YEARS FOR A REPLACEMENT HOSPITAL TO MEET THESE NEEDS.

THE VETERANS ADMINISTRATION FIRST DECIDED TO SUPPORT THE

MINNEAPOLIS HOSPITAL (WHICH INCLUDES 120 NURSING HOME BEDS -- CURRENT FACILITY HAS NONE) IN 1979. AND FOR EACH OF THE LAST THREE 5-YEAR PLANS (1980-82), THE MINNEAPOLIS PROJECT HAS BEEN RANKED AS THE VA'S TOP PRIORITY.

OUR HOSPITAL HAS BEEN STUDIED AND RESTUDIED, ITS DEFICIENCIES AND SHORTCOMINGS OF SPACE AND DESIGN HAVE BEEN WELL DOCUMENTED. WE HAVE ACTUALLY GONE THROUGH THE REVALIDATION PROCESS. SO I AM VERY INTERESTED IN WHAT TRANSPIRES HERE TODAY.

HOWEVER, NOW, AFTER GOING THROUGH THE REVALIDATION PROCESS, AND HAVING BEEN TOLD TO GO AHEAD AS PLANNED, WE ARE STILL WAITING TO BE INCLUDED IN THE VA'S BUDGET REQUEST. WHY?

WHY, TOO, DOES OMB NOW COME UP WITH A PROPOSAL, VERY MUCH LIKE WHAT CONGRESSMEN SABO PUSHED FOR EARLIER, TO CUT BACK ON THE NUMBER OF BEDS AND THE SIZE OF THE HOSPITAL?

I, FOR ONE, WOULD LIKE TO KNOW IF WE NEED TO REINVENT THE WHEEL EVERY YEAR IN ORDER TO GET OUR REPLACEMENT HOSPITAL. I CAN UNDERSTAND, TO SOME DEGREE, THE DESIRE OF NEW ADMINISTRATORS TO REVIEW PROJECTS THAT HAVE NOT YET BEEN FUNDED. HOWEDVER, IT DOES NOT MAKE SENSE TO DELAY, AS IN OUR CASE, A 1981 CONSTRUCTION DATE UNTIL 1984.

I MAKES EVEN LESS SENSE TO DELAY IN ORDER TO REVIEW SOME PROJECTS, ONLY TO HAVE OTHER PROJECTS AVOID THIS REVIEW AND JUMP AHEAD IN RANKING.

I HOPE THIS COMMITTEE WILL RECEIVE ANSWERS TO SOME OF THESE QUESTIONS TODAY.

THANK YOU AGAIN FOR THIS OPPORTUNITY TO PRESENT MY REMARKS.

STATEMENT OF THE HONORABLE BERKLEY BEDELL BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE COMMITTEE ON VETERANS AFFAIRS

DECEMBER 14, 1982

MR. CHAIRMAN and members of the Subcommittee, I would like to express my sincere appreciation for the opportunity to share with you my support for conversion of the St. Joseph's unit of the Marian Health Center in Sioux City, Iowa into a veterans nursing facility.

I have been working toward obtaining this veterans nursing facility for some time and I am pleased to continue my efforts on behalf of our veterans through my testimony today.

With only 8,500 nursing home beds in the Veterans Administration system presently, I believe an obvious need exists to plan for the expected increase in the number of World War II and Korean conflict veterans who will become eligible for and will require VA medical care in the coming years. Former VA Administrator Robert Nimmo has indicated that in Medical District 23, which encompasses Iowa, Nebraska, and a portion of South Dakota, there is a need for approximately 300 VA nursing home care beds.

A study of the veterans population in the Sioux City area shows that in the 23-county area (12 Iowa counties; 8 Nebraska counties; 3 South Dakota counties) a veteran population of 52,740 exists today. Approximately 11% of these veterans are now 65 years of age or older. Based on accepted planning guidelines, a dramatic shift is expected. By 1990, it is expected that 9% of this age group will require institutional care; two-thirds of that 9% will require skilled/intermediate level care; and 50% of that group will request that care through the Veterans Administration medical system. Thus, a conservative estimate of nursing home bed need by 1990 for our veteran population in the Siouxland area is approximately 400.

Presently in the State of Iowa, 65% of the nursing home care is provided by the State Veterans Home located in Marshalltown, Iowa--200 miles from the Sioux City area. An additional 20% of the required nursing care is provided through a facility in Knoxville, Iowa, more than 200 miles from Sioux City. In Nebraska, the nearest nursing home care facilities are located in Norfolk and Omaha, both a significant distance from the Sioux City area. In South Dakota, the major institutional resource for veterans is located in Hot Springs--some 400 miles from Sioux City.

Clearly, there is a need in the tri-state area for a facility that will be accessible to our veterans and that will support continued contact with family and friends.

In addition to the need to provide adequate medical care services to our veterans, I recognize the need for budgetary constraints. For this reason, I believe that converting the St. Joseph's unit of the Marian Health Center into a nursing home facility for veterans of the 23rd Medical District addresses not only the needs of our veteran population, but also that of the present economic and budgetary environment. A General Accounting Office report recommended that the Veterans Administration revise its criteria for nursing home construction projects to consider local conditions or less costly alternatives. The available facility at the Marian Health Center could provide the VA with readily adaptable lease space at a fraction of the cost of new construction.

In addition, such a Sioux City facility would have excellent access to a full range of inpatient, outpatient, ancillary and support services through contract with the Marian Health Center.

Mr. Chairman, I believe that in light of the facts I have outlined in this testimony, there is a clear need for a skilled/intermediate nursing care facility to serve the growing numbers of aged veterans in the Siouxland area or Iowa, Nebraska and South Dakota. I have contacted the Veterans Administration this summer and have recently joined in sending a letter to request that the Veterans Administration give serious consideration to this proposal, which would meet the long term health care needs of our veterans at a reasonable cost.

Mr. Chairman, members of the Subcommittee, thank you for the opportunity to share with you this plan for improved health care service to the veterans of our Nation.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

on

VA HOSPITAL CONSTRUCTION

DECEMBER 14, 1982

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
DECEMBER 14, 1982

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to present its views during this oversight hearing on the Veterans Administration medical construction program. May we say that the Subcommittee's consideration of this important issue could not be more timely, particularly in consideration of the recent disclosure of a move by the Office of Management and Budget to reduce the size of the replacement VA hospital in Minneapolis by 200 acute care beds.

To The American Legion such a scheme is untenable and preposterous, and we beg your indulgence, Mr. Chairman, in permitting us to react to OMB's action during this forum. As we have pointed out to this Subcommittee in the past, VAMC Minneapolis is one of the most sophisticated hospitals in the VA medical care system. It is a tertiary care hospital, with 25 specialty wards, that does most procedures, including kidney transplants and open-heart surgery. Minneapolis serves as a referral hospital for more than 25 other VA hospitals in a seven state area.

The average daily patient census for FY 1983 to date at the Minneapolis facility is 602 veterans in its 738 acute care beds. However, on December 2, the ADPC was 641 patients, reflecting a bed occupancy rate of 86%. There are no nursing care beds. The design for the replacement hospital calls for 725 acute care and 120 nursing home care beds. Following OMB's plan to its illogical conclusion, the replacement hospital would have an acute care bed capacity of 525 - not even enough beds to accomodate the current patient load - much less the larger number of veterans that are expected to seek treatment at the Minneapolis facility by 1990, projections of which are based upon the emigration of veterans to that state, and the increasing age of the veteran population. The number of veterans 65 years and older in the Minneapolis area is expected to increase 142 percent by 1990, from 54,040 in 1980 to 127,330. This will significantly impact upon the demand for health care services at VAMC Minneapolis.

In order to truly illustrate the impact such a bed reduction would have we must point out that VAMC Minneapolis currently treats about 18,000 veteran patients per year. To reduce the acute care bed level to 525 would decrease the number of patients by approximately 6,500, or over one-third of the current annual treatment level.

The design funding for the badly needed replacement hospital was appropriated by Congress in FY 1981, and it is our understanding that construction funding is to be considered for appropriation during FY 1984.

Although we are unaware of the motive of the Office of Management and Budget for taking this action, the fact that it was done does not surprise The American Legion. This is not the first instance in which OMB has taken advantage of the absence of an

Administrator to initiate an attack on veterans programs. It was for that reason that our National Executive Committee, upon the announcement of Mr. Nimmo's resignation, approved a resolution calling for the Legion to encourage the President to immediately nominate as Administrator a veteran who has demonstrated compassion for and a clear understanding of the needs of his or her fellow veterans; an individual whose background clearly suggests a willingness to be an effective spokesman for veterans, and whose experience in executive management is sufficient to effectively administer an agency of the size and scope of the Veterans Administration. A telegram bearing this message was dispatched to the President by our National Commander immediately following approval of the resolution, as a result of the Legion's concerns regarding the ongoing negotiations between VA and OMB with respect to the FY 1984 budget.

The action taken by OMB is a clear example of the potentiality for danger created when a vacuum exists in the leadership of the Veterans Administration.

We offer the thought to the Subcommittee that it should request of OMB Director David Stockman the reasons for calling for the 200 bed reduction in the Minneapolis facility despite the fact that the project had undergone extensive Congressional oversight; and his justification for taking such action sans communication with the House Committee on Veterans Affairs.

The VA medical care system is a multi-billion dollar capital investment of the Federal Government. As you know Mr. Chairman, it is an aging and deteriorating system in which there are a total of 172 hospitals. In addition to the fact that many of the hospitals are aging structures, they also were not configured to adapt to the practice of modern medicine. Therefore there is an immediate and ongoing need for renovation and replacement of facilities within the VA system, which brings us to the subject of the five year plan.

The Veterans Administration Five Year Medical Facility Construction Plan is a projection of the facility improvements and construction needs of the Department of Medicine and Surgery for a five year period, including a prioritized listing of the medical centers that DM&S has determined are most in need of construction, replacement or major modernization.

The five year plan for Fiscal Years 1983 - 1987 identifies 252 major construction projects with an estimated construction cost of over $5.3 billion.

The five year plan is reviewed by the full Committee and approved or modified. Further review is provided by the Appropriations Committee, and the same review process is carried out in the Senate, so that the VA construction program is given oversight by at least four Congressional Committees prior to final approval and appropriation of funds. The American Legion is confident that having undergone the review mechanisms within VA and the scrutiny of Congress, the five year plan is reflective of the actual needs within the VA medical care system.

It is most unfortunate that the Legion as a consumer advocate for veterans is unable to address the major construction projects for Fiscal Years 1984 - 1987, as former Administrator Nimmo saw fit to undertake a revalidation of these projects, which he first announced amid a flurry of fanfare and misleading information on February 19. The study and revalidation process was completed by the Facility Planning and Construction Committee, and their report was submitted to the Office of Management and Budget without offering any opportunity for external review or comment. OMB has embargoed the report pending FY 84 Budget negotiations, and therefore we are without a scintilla of information on the specific results of the study.

However, as National Commander Al Keller, Jr. advised the full Veterans Affairs Committee in his statement of September 21, what The American Legion did in response to Mr. Nimmo's initiative was to extract from our file of site visit reports by our Field Representatives, information relating to construction needs at the identified projects.

Exhibits have been prepared for each of the projects, and where necessary the pertinent data has been updated. The exhibits contain information extracted from the Field Reports including comments and recommendations on the construction and space needs by our Field Representatives, responses by the Chief Medical Director to the recommendations, statements by the medical center Directors or other VAMC officials, and in many cases, comments by local American Legion officials.

Our information indicates clearly to us that in almost every instance the projects developed by the VAMC Directors were reflective of the actual needs within the system, and Mr. Chairman, we would welcome the opportunity to provide you with copies of our reports for perusal and any other use deemed appropriate by the Subcommittee.

The General Accounting Office report presently under consideration of the Subcommittee entitled "Opportunity to Reduce the Cost of Building VA Medical Facilities" appears to be a concise and valid document, content of which is quite revealing with respect to the reasons for cost overruns on major construction projects.

GAO was requested by this Subcommittee to review VA's major construction program with particular emphasis on the reasons for cost growth in the program, the reasons for large numbers of changes to architect/engineering and construction contracts, and the cost these changes added to projects.

Following identification of 34 recently completed major construction projects which were built from the ground up, 10 projects were selected for detailed review. For each project, GAO reviewed the funding history, award of design and construction contracts, and changes to the contracts. Documentation contained in VA's construction project files relating to changes in design and construction contracts was reviewed, VA officials were interviewed, and applicable agency regulations and manuals were reviewed.

The report illustrates several points that are of concern to The American Legion. For instance, it is stated that VA frequently modified A/E contracts to accommodate changes requested by DM&S. The 10 A/E contracts reviewed were modified 198 times, increasing their cost 18.8 percent ($1.4 million). Design completion slipped on nine contracts an average of 9.6 months (ranging from 2 weeks to 19.5 months). VA changed the 11 construction contracts 1,847 times, most of which were initiated by DM&S to provide additional features it wanted in the facilities. We question why these features, or at least the majority of them, were not included in the original contracts.

Specific examples of the expense involved in making such changes follow:

> "At the beginning of the final design phase for the San Diego hospital, DM&S requested that an automated system be included to transport food and supplies. A modification was issued for $63,504. However, after spending $21,000 to develop this new system, DM&S determined the system would be too expensive and would not efficiently fit into the hospital. At the second review of the working drawings, DM&S requested the automated system to be deleted and the standard manual transport system be used. This redesign cost VA $75,609.
>
> "During the second review of the working drawings for the Tampa hospital, DM&S requested that a five-bed coronary care unit be included in the sixth floor nursing unit. This modification cost VA $3,628. Later, when the working drawings were 80-percent complete, DM&S requested this coronary care unit be moved to the special care nursing unit on the same floor. This redesign cost $10,000.
>
> "After final design was begun on the Phoenix hospital

addition project, DM&S determined that the hospital's existing surgical suite would not meet the space requirements for a new residency training program. DM&S requested the A/E firm to include a modern surgical suite in the new building. This modification cost VA $51,100 and delayed completion of the working drawings about 6 months."

The GAO report further explained the manner in which VA's failure to provide the A/E firms with complete data packages during the final design phase caused additional modifications to some contracts. Examples follow:

> "VA failed to include some equipment drawings in the original A/E package for the San Antonio hospital. As a result, design charges were necessary in the following areas: physical medicine and rehabilitation, psychiatric research, pathology, and oral research. In addition, VA added a requirement for a respiratory failure unit and relocated the kidney failure unit. The design changes and addition cost VA $13,246.
>
> "VA failed to include construction standards and specifications for exterior walls in the A/E package for the Sepulveda nursing home. As a result, the A/E firm developed its own exterior design. However, VA found this unacceptable and issued a modification to design the exterior walls to its standard. The redesign cost VA $3,666.
>
> "VA failed to furnish accurate dimensions for a stair and elevator tower that joined the Phoenix nursing home to

the hospital. As instructed, the A/E firm designed the nursing home so that it could be joined with a stair and elevator tower by separate project. However, during the development of working drawings for the tower, it became apparent that the dimensions VA had furnished were incorrect. After VA corrected the dimensions, the A/E firm had to redesign the nursing home so that it would be properly joined to the tower. The redesign cost VA $3,127."

What all of this leads the Legion to believe is that VA needs to be more precise in its planning of construction projects. A small number of necessary modifications during the planning, design and construction phases would be understandable. However, if the significant data on the examples of modifications requested by DM&S, or caused by error or indecision on the part of VA as reported by GAO are correct, it would appear to us that excessive and expensive changes are being caused by improper planning, and we await with interest an explanation by VA.

In this current climate of fiscal austerity it is becomming more and more difficult to secure adequate funding for the VA medical care program. And we will certainly not condone the wasting of precious dollars on unneccessary or frivolous modifications to construction projects. Perhaps the provisions of title III of PL 96-22, particularly the mandate that VA not increase the cost of a project by more than ten percent above the amount approved by the Veterans Affairs Committees, will necessitate improvement. At this juncture it is too early to tell.

The General Accounting Office adjunctly stated that an extension of the Advanced Planning Fund to allow VA to contract for final designs while Congress reviews the projects could reduce overall project costs. The Advance Planning Fund was created in 1978 so that VA could contract with architect/engineering firms for preliminary design work before projects are presented to Congress. GAO also pointed out in its report that the time it takes to complete medical facility construction projects could be reduced by up to 15 months by extending the Fund. On the other hand, if Congress did not approve or fund a project so designed, the final design costs would be wasted.

According to GAO, Congressional action would be necessary to extend the Fund by amending VA's construction authority under 38 U.S.C. 5001. The American Legion would support such legislation, given evidence that such an amendment would be cost-effective.

We thank the Subcommittee again for the opportunity to present our views at this time.

PARALYZED
VETERANS
OF
AMERICA

STATEMENT OF

FRANK R. DE GEORGE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE

THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

VETERANS ADMINISTRATION CONSTRUCTION

DECEMBER 14, 1982

Mr. Chairman and Members of the Subcommittee, Paralyzed Veterans of America appreciates this opportunity to express its views and concerns on the Veterans Administration's hospital construction program and plans. As you know, PVA's members all are veterans who have experienced spinal cord injury or dysfunction, and these veterans have considerable contact with the VA health-care system and the facilities in which the VA extends medical and health-care services.

PVA's statement will concentrate, basically, on two areas: first, it will examine the VA's construction plans, generally. Second, it will look into the needs of spinal cord injured veterans and examine some possible VA construction projects which would help ensure more adequate care for spinal cord injured veterans.

It is worth noting that some of PVA's comments dedicated to the VA construction program as it relates to SCI veterans are intended to actually save the government money, while providing those veterans with appropriate

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and timely care. Other observations likewise are aimed at providing all eligible veterans with adequate care at the least cost to the government.

Before discussing VA hospital construction plans and procedures in depth, PVA would like to take a moment to reflect on the debt that the Nation's veterans owe to the Chairman and distinguished Members of this Subcommittee. You, both individually and as a component of the full Committee on Veterans' Affairs, have worked diligently during the 97th Congress to have the Veterans Administration's medical and health-care programs and services funded as adequately as possible during this time of fiscal restraint. Cutting the VA's budget to the point where its health-care system could not function would be a blatant attack on the Nation's veterans, and each of you have worked to ensure that this attack would not be made.

Other attacks on the VA health-care system have, like unrealistic budget proposals, been thwarted largely because of the efforts of the Members of this Subcommittee. For example, the Office of Management and Budget would have placed veterans who are patients in VA facilities in the hands of for-profit contractors. Furthermore, this OMB directive would have undermined the authority of the Administrator of Veterans Affairs and of the VA's Chief Medical Director by greatly reducing their discretionary authority on ways to efficiently and effectively meet the needs of patients in VA facilities.

PVA would like to express its sincere appreciation to each of you for your diligence during the 97th Congress, and many Members of this Subcommittee have worked on behalf of the Nation's veterans for many, many years prior to this current Congress. We recognize that some Members of the Subcommittee will return during the 98th Congress, others will perhaps have new assignments, and some will not be present after this Session. For a number of years, now, it has been the Members of the Committees on Veterans' Affairs who have preserved the VA's integrity as a viable provider of services to the Nation's veterans: Members of these essential Commitees have led Congress to ensure that veterans' reasonable needs are met, and you have at times emphasized to various Administrations that policies and ideologies must not overshadow an essential fact, that the men and women who have served the

Nation in uniform are owed a debt which must not be forgotten. Thank you for your integrity and diligence.

It is possible, and maybe even probable, that Fiscal Year 1984 will again see the need for the Members of the Committees on Veterans' Affairs to lead Congress and the Administration toward providing amply for operation of the Veterans Administration and the programs and services which it provides to the Nation's veterans. Your vigilance will likely be needed again because the Nation continues to face economic difficulties and because caring for the needs of veterans is apparently not a high priority on the part of many policy makers, even on the part of policy makers who work tenaciously for a stronger national defense. PVA sees these two areas, national defense and caring for veterans, as two sides of the same issue, and we are pleased that the Members of the Committees on Veterans' Affairs have recognized this fact during past years--we trust that Congress will continue to appreciate the importance of veterans programs when it reconvenes in January 1983.

I. VA MEDICAL FACILITY CONSTRUCTION, GENERALLY

The failure to construct needed VA medical and health-care facilities has been one of the most troublesome veterans issues for quite some time: by "construction" PVA means both the building of needed new facilities and the maintaining of existing ones. It is a very serious matter that so many VA facilities are now in a state of decay, after a grateful Nation has provided them, and some are only marginally meeting the needs of the veterans who use them. Decaying facilities not only hamper patient usage of some VA medical facilities, but their poor condition makes it doubly difficult to recruit and retain highly capable health-care professionals. Thus begins a vicious circle of waste in which ailing veterans are too often caught.

As we all know, the VA is currently experiencing a freeze on construction whereby funds cannot be committed for the building of new facilities. The Administrator of Veterans Affairs announced this policy on February 19, 1982, pending a demographic review of the veteran population and particularly of those veterans who utilize VA health-care services and facilities. This review and concomitant construction freeze is an attempt by the

Administrator, according to him, merely to review veterans' needs and to provide long-term planning for new facilities aimed at meeting those needs in the most efficient and effective manner.

This construction freeze is based on completion of the proposed demographic study: on April 1, 1982, PVA testified before this Subcommittee that we were taking a close look at the "General Methodology Manual for Needs Assessment Studies," the guidelines which formed the basis of the Administrator's revalidation.

PVA hired a distinguished consulting firm to augment our examination of the Methodology Manual: the firm reported that the VA's methodology "deserves high marks" in that it "compares favorably to most in the general area of planning and needs assessment." The consulting firm's evaluation noted, however, that this Manual differs from traditional VA policies in that there is an emphasis on sharing with other health-care providers and there is a drive to assess the possibility of greater reliance on private sector health-care delivery systems. These are two points, you will recall, that PVA noted specifically when it testified on April 1, before this Subcommittee--it did not take a sophisticated study to warn veterans that revalidation could be used as a guise for dismantling the VA health-care system.

The VA's Facility Planning and Construction Committee (FPACC) has met several times with veterans service organizations, not so much seeking these organizations' recommendations as informing them of progress being made on the needs assessment study and of reiterating the VA's view that the agency must serve a growing number of veterans with a shrinking portion of federal funds.

At the April 1, 1982, hearing which, like this one, was dedicated to the VA's medical construction program, PVA emphasized that we are willing to cooperate fully with the Administrator of Veterans Affairs in his effort to improve long-term planning in order that VA facilities can be constructed where and in a manner whereby they will most effectively serve the needs of veterans. PVA continues in its dedication to an adequate, separate health care system for veterans that is cost effective and productive.

In its last meeting with the Facility Planning and Construction Committee, PVA was told that the demographic study was nearing preliminary completion. But, we have not yet been provided an opportunity to review the Committee's findings. Therefore, ten months after announcement of the revalidation policy, PVA requests of the VA that there be at least an interim update on what progress is being made toward completion of the study.

There are two serious concerns PVA has which mount as the construction freeze stays in effect: first, while the VA awaits its conclusions on construction of new facilities, veterans continue to require medical services, services which will not wait for a policy review. This point is an obvious one, but it is one of PVA's major concerns at a time when so many VA medical facilities are filled at or near full capacity.

Second, and quite obvious, construction costs are ever-rising, and any approved facilities will inevitably cost more than they originally would have. Even if the VA were to announce today that a given facility was approved, it would be many months before construction would be completed, and all the while costs would rise--contractors would naturally take into consideration these rising costs even if bids were offered immediately.

Based on these two considerations, the needs of veterans and the rising costs to be borne by taxpayers, PVA urges the Veterans Administration to move forward quickly to end the freeze on construction projects. PVA feels confident that our concerns are shared by the Members of this Subcommittee, who seek to have the VA be responsive to veterans' needs in a fiscally responsible manner. Therefore, a factual demographic study must not be allowed to become a stalling tactic whereby the construction of needed VA facilities is delayed or cancelled merely for policy reasons which would not benefit those for whom the VA health-care system exists.

II. VA HOSPITALS: A VITAL PART OF THE FEDERAL INFRASTRUCTURE

There is a growing concern in Congress and the Administration over the plight of the unemployed citizens of this country, a concern which PVA shares. And, there is also serious consideration being given to stabilizing many of our decaying structures such as highways, bridges, and mass transit systems. PVA, again, agrees that some of our Nation's most important and prized accomplishments must not be allowed to deteriorate further.

It is a praiseworthy proposal, that unemployed persons be put to work refurbishing federal assets, because those without gainful employment would benefit and it would restore faith in many Americans to see major accomplishments being made to maintain and to improve upon our national resources.

Whether the restoration/employment measure is financed solely trough increased federal taxes on gasoline, through general revenues, or through some combination of sources, PVA asks that Veterans Administration medical and health-care facilities be regarded as part of the federal infrastructure which is to receive needed construction and renovation.

VA health-care facilities, like the interstate highway system, are part of the Nation's assets and both were designed to contribute to the national defense. The interstate highway system was intended to allow rapid mobilization in times of national emergencies--VA hospitals were meant to care for the men and women who have answered the Nation's call to service during times of crises.

It would not be inconsistent with the aims of a restoration/employment measure to include VA facilities as objects for repair, and it would be giving needed attention to the urgent situation which surrounds many VA facilities. Too many such structures are being allowed to deteriorate even though their assigned purpose is to care for the increasing number of veterans who stand in need of health and medical services.

The Brockton, Massachusetts, VA Medical Center is an example of the decay which PVA has observed within the VA health-care system: the situation at Brockton has existed for a number of years and continues to worsen. Quite briefly, the Spinal Cord Injury Center there is in urgent need of renovation. And, it is filled to capacity while other SCI veterans await admission. Yet, in the face of these facts the Veterans Administration speaks of reducing SCI beds in that facility, largely because of the facility's poor condition and the major renovations which would be required to make the SCI facility truly operative. It is obvious that more SCI beds are needed at the Brockton facility.

Admittedly, the Brockton VAMC's Spinal Cord Injury Center is a particularized example of the type of decay which PVA has seen occur within the VA's medical and health-care facilities. But, it represents one of the grandest, most innovative fields of care for which the VA is known, because the VA has led the Nation in development of spinal cord injury care--and even that noble venture is being allowed to deteriorate due to economic difficulties and fiscal policies.

Numerous VA facilities need prompt attention, and many, such as Brockton, are located in geographic areas where capable workers are unemployed. At a time when the Nation seeks to restore national assets, to revive the productivity of its workers, and to strengthen the national defense, it is only reasonable that VA medical and health-care facilities, which are definitely a large part of the federal infrastructure, be provided for in any restoration/employment measure created by this Congress. PVA would support any reasonable measure which included this provision, but we would find it very difficult to endorse a measure whose clear statement was that VA facilities and the needs of veterans are not part of our national priority.

III. CONSTRUCTION REQUIREMENTS OF THE VA SPINAL CORD INJURY PROGRAM

Mr. Chairman and Members of the Subcommittee, it is a pleasure to begin this analysis of the construction requirements of the VA Spinal Cord Injury Service with a positive note: on July 28, 1982, this Subcommittee conducted an oversight hearing dedicated to examining the operation of the VA's SCI program, and the Chairman and Members dedicated themselves to directing the Veterans Administration to begin analyzing ways to meet certain needs of spinal cord injured veterans. Most notable, the Chairman asked the VA to begin a review of the special needs of aging SCI veterans.

One topic which PVA discussed at length at the hearing this summer was the need for a long-term care facility at Hines VA Hospital in Chicago, Illinois. A brief recapitulation of our comments during that hearing are in order, to illustrate the positive impact that Congressional attention and influence have in causing veterans' needs to be met.

PVA pointed out that at Hines there is one of the VA's largest SCI acute-care facilities, but no long-term care facility exists. The VA's Department of Medicine and Surgery has for some time seen the need for a long-term SCI facility at Hines, and one continues to be listed in the VA's Five Year Construction Plan; however, despite the Chief Medical Director's best efforts, construction of this needed facility continuously has been delayed.

The Chief Medical Director consulted PVA for over two years concerning feasible alternatives to the construction of the needed 40-bed long-term care facility, with the alternative being to bridge the gap between urgent, current demands and the construction of a suitable facility. Despite this two-year effort, no adequate solution had been reached by the VA prior to this Subcommittee's hearing on July 28. The most recent proposal as of that date was to contract with nursing homes for the care of SCI veterans, and it was decided by those in charge of the Hines facility that sixteen (16) SCI veterans would be sent on a contract basis to non-VA nursing homes. Others would be placed in the Hines VA nursing home, and still others would be dispersed throughout the existing acute-care SCI facility.

During the July 28, hearing, PVA pointed out several problems inherent in placing SCI patients who are in need of long-term care in non-specialized facilities. For example, SCI veterans too often are returned for hospitalization in VA facilities after episodes in non-specialized nursing homes because personnel in those facilities generally lack the training and attentiveness required from those who care for SCI patients, especially for aging SCI patients. Care of SCI patients in general nursing homes as often as not ends in a worsening of the individual patient's condition for a number of reasons, and the deleterious effects create the need for expensive medical treatment. Health-care statistics support PVA's observations that non-specialized personnel are not able to recognize symptoms of decubitus ulcers, urinary tract infections, and other ailments common to SCI patients, and infections are perhaps the worst enemy of SCI patients who must reside in non-specialized nursing homes.

At the time of the July 28, hearing, PVA felt that a number of problems combined to the detriment of SCI veterans at Hines who require long-term care: VA health-care experts had called for construction of the facility but the VA remained unable to respond to the emergency situation which had arisen, either because Congress had made available only limited funding or because the Administration refused to spend available monies for the care of needy veterans. In short, long-range plans for the Hines facility were inadequate and interim solutions were unacceptable.

Even though long-range plans for the construction of a 40-bed long-term care facility at Hines remain somewhat uncertain, there has been worked out an acceptable interim solution, the essential elements of which are as follows:

°The healthiest SCI patients in the SCI unit will be moved into the VA's new general nursing home facility;

°SCI patients who are currently medically unstable, but who are in need of long-term care, will remain in the acute-care SCI facility until their conditions improve, at which time they will be transferred to the nearby VA nursing home;

°SCI patients who need long-term care but who will continue to be medically unstable will remain in the acute-care facility;

°Seven (7) SCI-trained FTEE will be assigned to the nursing home specifically to care for the SCI patients.

This interim solution was reached after a meeting on October 15, 1982, at which the Veterans Administration was represented by Dr. Earl Brown, Associate Deputy Chief Medical Director, and Mr. John R. Fears, Director of the Hines VA Hospital. PVA was represented by members from the Washington, D.C., office and from the Vaughan Chapter, located in Chicago.

We are grateful to the Veterans Administration for its cooperation on this important matter, and we continue to feel that this Subcommittee fulfilled its leadership role by conducting the SCI oversight hearing on July 28, 1982, a hearing which examined research efforts aimed at curing spinal cord injury and which gave a close look at the VA's ability to meet the needs of SCI veterans.

It, of course, remains evident that the situation at Hines will not be resolved permanently by means of this interim plan, because needed acute-care beds are being utilized for long-term care. And, SCI veterans who are transferred to the VA general nursing home (even though they may be accompanied by qualified SCI-care professionals) are occupying spaces needed by non-SCI veterans. Director Fears emphasized in a memorandum of October 18, 1982, that his facility "could not solve the overall problem for long-term care until a unit is constructed," and, he noted, "Dr. Brown agreed after reviewing the problem that a long-term care unit is necessary. He assured the PVA he would do everything in his power to get this unit built as soon as possible."

III(a). DEMOGRAPHICS OF IN-PATIENT SCI VETERANS' USE OF VA HEALTH-CARE SYSTEM

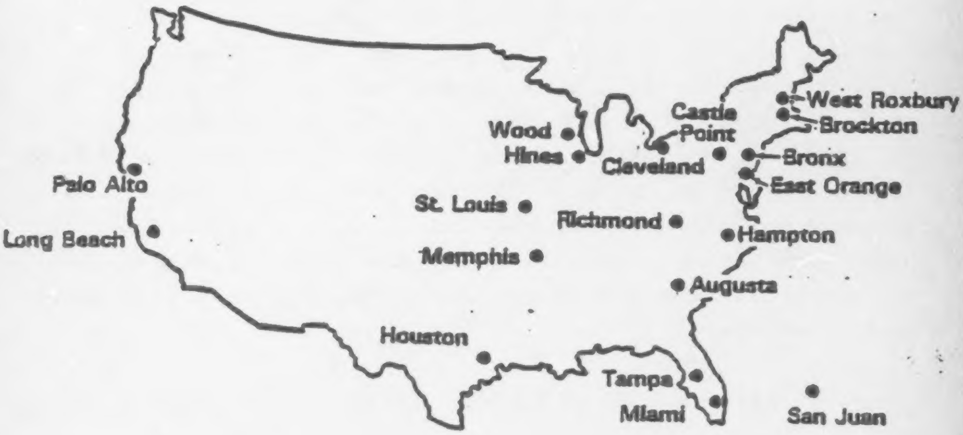
The Veterans Administration and PVA have been working closely together to study the demographics of SCI veterans, in an attempt to more accurately identify the location of such veterans and to examine their usage of the VA health-care system. That study, being prepared by the VA, is nearing completion, and PVA would like to express its appreciation to Dr. Juan Fonseca, Chief of the Spinal Cord Injury Service, for inviting PVA to participate in this informative analysis. Even though the study is not yet completed, there are available usable statistics which have been gathered in the process of preparing it.

PVA feels that this is a quite comprehensive study of SCI veterans, and it should meet the methodology requirements which the VA Administrator has established for analysis of veterans as users of VA medical and health-care facilities and services. It would appear, therefore, that progress could be made at this time toward meeting many of the construction requirements of the

Spinal Cord Injury Service, which is an important element of the Department of Medicine and Surgery.

In understanding the importance of this demographic information, it would first be helpful to review a map of the United States, on which the location of VA SCI Centers is noted:

Location of VA SCI Centers


West Roxbury
Brockton
Castle Point
Wood
Hines
Cleveland
Bronx
East Orange
Palo Alto
St. Louis
Richmond
Long Beach
Hampton
Memphis
Augusta
Houston
Tampa
Miami
San Juan

In addition to these SCI Centers, there is an SCI Service-approved out-patient clinic at Sepulveda, California.

Furthermore, there are two out-patient clinics which care for SCI patients but which are not officially part of the SCI Service. They are located in Phoenix, Arizona, and Indianapolis, Indiana. These two clinics are headed by nurse practitioners who have been trained in the special needs of SCI patients.

All three SCI out-patient clinics have proven to be very effective and beneficial: they have helped reduce the load being placed on SCI Centers, or they are filling the void where there are numerous SCI veterans but there is no convenient SCI Center to care for their needs.

These nineteen SCI Centers are hard-working facilities dedicated to serving SCI veterans, as the following distribution of discharges of in-patients reveals:

DISTRIBUTION OF IN-PATIENT DISCHARGES OF SCI VETERANS
FROM THE VA'S SCI CENTERS AND FROM ALL VA MEDICAL CENTERS
FY76 THROUGH FY82

		BEDS	N	%	%'
1.	Memphis	160	5109	13.93	7.37
2.	Long Beach	197	4528	12.34	6.54
3.	West Roxbury	100	4105	11.19	5.93
4.	Richmond	145	3891	10.61	5.62
5.	Wood	56	2732	7.45	3.94
6.	Tampa	42	2101	5.73	3.03
7.	Palo Alto	30	2074	5.66	2.99
8.	Hines	135	1816	4.95	2.62
9.	Castle Point	58	1509	4.11	2.18
10.	Miami	37	1386	3.78	2.00
11.	Houston	22	1343	3.66	1.94
12.	Cleveland	60	1329	3.62	1.92
13.	St. Louis	32	995	2.71	1.44
14.	San Juan	20	875	2.39	1.26
15.	Bronx	80	790	2.15	1.14
16.	Hampton	22	639	1.74	.92
17.	East Orange	36	623	1.70	.90
18.	Brockton	58	435	1.19	.63
19.	Augusta	60	395	1.08	.57
	Totals	1350	36,675	100.00	52.94

N - Number of Discharges

% - Percentage of Discharges from SCI Centers

%' - Percentage of Discharges from all VAMC's, which means that nearly half (47.06 percent) of all SCI discharges were made by non-SCI facilities.

It would be too cumbersome in a testimony such as this to list all 153 non-SCI facilities within the VA and the number of discharges they made over a significant period of time. However, thirty such facilities made over 400 discharges between Fiscal Year 1976 and Fiscal Year 1981:

1.	Dallas	774
2.	Portland	735
3.	Minneapolis	683
4.	Ann Arbor	679
5.	San Antonio	637
6.	Seattle	612
7.	Little Rock	611
8.	Phoenix	603
9.	Birmingham	588
10.	Charleston	560
11.	Durham	519
12.	Indianapolis	514
13.	Atlanta	513
14.	Oklahoma City	503
15.	Denver	499
16.	San Diego	496
17.	Columbia, SC	488
18.	Louisville	482
19.	Shreveport	476
20.	Jackson	471
21.	Temple	467
22.	Lexington	453
23.	Pittsburgh (Aspinwall)	451
24.	New Orleans	428
25.	Gainesville	427
26.	Kansas City	426
27.	Nashville	424
28.	Albuquerque	416
29.	Cincinnati	412
30.	Allen Park	407

Nine other non-SCI facilities made at least 300 SCI discharges during this same time period, and twenty-four such general facilities made at least 200 SCI discharges. In all, there were 32,603 SCI in-patient discharges made by non-SCI facilities during these six years.

It is also meaningful to illustrate the number of SCI discharges by VA medical district and region, and the following table contains this useful information:

DISCHARGES OF IN-PATIENT SCI VETERANS FROM VAMC'S BY DISTRICTS AND REGIONS FY76 THROUGH FY81

DISTRICTS	NUMBER OF DISCHARGES N	NUMBER OF DISCHARGES %		REGIONS N	REGIONS %
1	5,432	7.84	(Brockton, West Roxbury)	#1 - 10,464	15.10
2	1,029	1.49			
3	4,003	5.78	(Bronx, Castle Point, San Juan)		
4	1,278	1.39	(East Orange)	#2 - 9,392	14.23
5	952	1.17			
6	998	1.44			
7	5,097	7.36	(Hampton, Richmond)		
8	1,467	2.12			
9	2,196	3.17	(Augusta)	#3 - 16,630	24.00
10	1,713	2.47			
11	6,496	9.38	(Memphis)		
12	4,336	6.26	(Miami, Tampa)		
19	1,889	2.73			
13	2,155	3.11	(Cleveland)	#4 - 11,339	16.37
14	1,338	1.93			
15	756	1.09			
16	3,285	4.74	(Wood)		
17	2,187	3.16	(Hines)		
21	1,618	2.34	(St. Louis)		
18	1,083	1.56		#5 - 8,793	12.69
20	4,398	6.35	(Houston)		
22	922	1.33			
23	1,190	1.72			
24	1,200	1.73			
25	1,711	2.47		#6 - 12,160	17.55
26	5,589	8.07	(Long Beach)		
27	2,864	4.13	(Palo Alto)		
28	1,996	2.88			
Total				69,279	

SCI Centers Are Noted In Parentheses

III(b). SPECIFICALLY NEEDED VA SCI CENTERS

It is evident from the previously cited data that the VA Spinal Cord Injury Service is in need of expansion, a finding long recognized by the VA's Department of Medicine and Surgery.

The VA has prepared two comprehensive studies of SCI veterans and the demands they will make on the VA health-care system. These studies are entitled "The Spinal Cord Injury Program Plan: FY 1980--1987" and "Estimated Bed Requirements of the Spinal Cord Injured Veteran, 1985--1990." "The Spinal Cord Injury Program Plan" is a broad analysis of the VA's SCI program (to include staffing needs, medical specialties required, and other appropriate health-care matters), and at the very core of the study is the assumption that VA SCI Centers will be placed where needed in order to better serve veterans who experience spinal cord injuries. It is important, also, that at the time of publication there were only 14 non-VA SCI Centers in the Nation and the VA's Centers were accepting non-veterans on a space-available basis. Currently, though, many VA SCI Centers have long waiting lists of veterans who are in need of care.

In early 1980 the Veterans Administration had 1,365 SCI beds, which is about the same number as exists today, two years later. At that time the VA estimated that by Fiscal Year 1985, 1,845 beds as a minimum would be needed in the SCI Program. The VA admitted that this figure was low and that it was based on an assumption that only 25 percent of all SCI veterans would require hospital services in any given year and that there would be no more wars. If 100 percent of existing SCI veterans required hospital services in a given year, the VA estimated that 6,439 SCI beds would be needed. PVA maintains that the accurate figure is probably some place between these two estimates. Either way, increased SCI services and beds are urgently needed. (VA's "Estimated Bed Requirements of the Spinal Cord Injured Veteran, 1985--1990")

It is difficult to ascertain from the data available on SCI veterans' demographics and their usage of the VA system what exactly is the frequency of use; however, the following statistics are helpful in understanding that there existed only 1,365 VA SCI beds when the data was gathered, but the VA system treated 16,279 individual SCI veterans between FY 1976 and FY 1981:

FREQUENCY OF IN-PATIENT DISCHARGES FOR SCI VETERANS
FROM VAMC'S
FY76 THROUGH FY81

DISCHARGES	N	%
1	3,895	23.90
2	2,755	16.90
3	2,177	13.30
4	1,703	10.40
5	1,357	8.30
6	1,078	6.60
7	847	5.20
8	622	3.80
9	467	2.80
10	356	2.10

11	250	1.50
12	198	1.20
13	133	.81
14	109	.67
15	74	.45
16	69	.42
17	48	.29
18	28	.17
19	26	.16
20	15	.09
21	17	.10
22	6	.03
23	12	.07
24	2	.01
25	6	.03
26	6	.03
27	5	.03
28	1	.006
29	3	.01
30	1	.006
31	2	.01
32	1	.006
33	1	.006
34	3	.01
35	1	.006
36	1	.006
37	1	.006
41	1	.006
58	1	.006
64	1	.006
	16,279	100.00

Based on these inconclusive statistics, and even more strongly based on the observation that nearly all of the VA's SCI Centers are filled to capacity continuously (depending largely upon their location) it is apparent that the VA requires more SCI beds and additional SCI Centers if it is to meet the needs of SCI veterans.

Accurate placement of new SCI facilities is as important as is the expansion of the system by the addition of more beds: the above-mentioned map, which shows the location of existing SCI Centers, and the cited discharges of SCI veterans from VA Medical Centers by districts and regions, combine to help show where new SCI Centers should be located.

There is a drastic need for the establishment of an additional Spinal Cord Injury Center in the Southwest because of the great distances separating SCI veterans from existing SCI Centers. Medical Region 6 includes two SCI Centers, but this Region covers an enormous area of land ranging from western Texas through California. Furthermore, the adjoining Medical Region 5 contains only one SCI Center, Houston, Texas, which is nearly as close to New Orleans, Louisiana, as it is to Dallas, Texas. North of Houston there is not another SCI Center in the United States.

It is an established fact that SCI Veterans are moving to the South and to the Southwest, where the climate suits their needs better and where the cost of living is less than in the North and Northeast. Yet, there are not ample VA SCI Centers in the South and Southwest to treat these veterans sufficiently in a timely manner.

First, PVA requests the establishment of a new SCI Center at the Albuquerque, New Mexico, VA Medical Center: this proposed center would serve veterans in New Mexico and part of Texas, Kansas, Colorado, and Arizona.

When it became evident to PVA that demographics require establishment of a new SCI Center at Albuquerque, we investigated the site thoroughly, and we have discussed our findings with the Veterans Administration.

There is on the campus of the Albuquerque VAMC a five-year old building scheduled for demolition. This building, which is structurally sound, is less than one hundred feet from the site of the new replacement hospital, and it handily meets many of the requirements for an SCI Center in that accessibility in this one-story facility would not be a problem.

The VA estimates that for less than $5 million this existing structure could be made into a fully operational SCI facility, and the fact that it already exists would greatly reduce the lag time before such a Center could be established in Albuquerque.

There are other important considerations, also, and they again point to Albuquerque as a logical place for the establishment of a new SCI Center. There are on the campus additional uncommitted grounds, where a long-term SCI facility could be established in the future. Co-location of long-term SCI facilities with SCI Centers is of paramount importance, as has been discussed briefly when Hines VA Hospital was used as an example of the beneficial role this Subcommittee has played in resolving seemingly insurmountable obstacles which have hindered the proper care of SCI veterans.

The Albuquerque VA Medical Center is affiliated with the University of New Mexico School of Medicine which is located a short distance away: PVA regards this affiliation to be in the best interest of SCI veterans who would occupy that SCI Center. There are about 181,000 veterans residing in the Albuquerque service area, and in Medical District 25, in which there is not an existing SCI Center, there are approximately 686,500 veterans.

Second, demographics support establishing an SCI Center in Dallas, Texas. The Houston, Texas, SCI Center, while it may appear to be ample for the State of Texas, is not. The Houston facility's occupancy rate remains near 100 percent, according to VA reports and PVA's observations. VA reports for the period ending May 31, 1982, show that at Houston there was an average daily census of 21 patients for 22 beds, with one bed remaining in reserve for emergencies, and 8 other SCI veterans were hospitalized in non-SCI beds. In short, this 22 bed facility is treating on the average 29 veterans at a time.

The addition of a 60-bed SCI Center in Dallas would only meet the needs of SCI veterans in that catchment area who are being treated in general hospitals--it would be a minimal (but vitally needed) addition to the SCI Service in that it would help take care of current requirements which are not being amply met. For it to address the continuing influx of SCI veterans to the Southwest, the facility would need considerably more than 60 beds. The Dallas VAMC already reports the highest number of SCI discharges of any non-SCI facility in the VA health-care system.

III(c). SPECIFICALLY NEEDED VA SCI LONG-TERM CARE FACILITIES

PVA recognizes that there is a requirement for additional long-term care SCI facilities within the VA health-care system. We have seen the harmful effects which have arisen when SCI veterans have been placed in general nursing homes (both VA and contract providers) because those facilities lack skilled and experienced personnel who are familiar with the needs of SCI veterans. Furthermore, as this Subcommittee noted on July 28, during the investigation of Spinal Cord Injury care and research, there are aging SCI veterans whose complex requirements have not been fully addressed by the VA, but adequate specialized long-term care is one readily identifiable requirement which can be met.

Specialized SCI long-term care facilities must be co-located with VA SCI Centers, if they are to adequately serve those veterans who need the services of such facilities. SCI Centers can provide the needed medical and health-care expertise, and long-term care facilities can provide the sustaining health services required by these SCI veterans without occupying expensive SCI Center beds except when they are urgently required.

First, Tampa, Florida, which already has an excellent 42-bed SCI Center, is in need of having a long-term care facility co-located with it. There has been some discussion of placing a long-term care facility at St. Petersburg, Florida: while this would help meet the requirements of the numerous older SCI veterans who continuously move into Florida, it would not have available to it the SCI Center nor the medical school affiliation--should the Center be moved to St. Petersburg to accommodate the long-term facility, the medical school affiliation would be lost.

PVA's efforts to have established at the Tampa VAMC a long-term care facility have been frustrating, as we have witnessed needless delays, delays which will cost taxpayers more money and which have already hindered the VA's ability to care adequately for SCI veterans in Florida. It should be evident to the Veterans Administration that the Tampa SCI Center needs to be supplemented with a long-term care facility: the Center now works at or within one bed of 100 percent occupancy on a daily basis, it is overcrowded, and there is a continuous waiting list for patient admission. (Only California has more SCI veterans than Florida.)

About three years ago the VA began negotiations to acquire property adjacent to the Tampa VAMC campus, upon which there was to be constructed an SCI long-term care facility and parking spaces for both VA employees and patients and visitors at the medical center. For whatever reason, internal discussions and arguments prevailed in the VA, until the agency lost the option to acquire this valuable and needed land. Now, a consortium of physicians (at least one of whom is a former VA employee) has purchased the land and is offering to sell it to the VA at approximately twice the amount that was sought by the original sellers. In short, even in the face of an obvious need to acquire this property, the VA did not move in a timely manner and ailing veterans and taxpayers are the ones who are already suffering or will suffer when and if the VA decides to construct a long-term care facility which is needed by the veterans who live in Florida.

Second, as noted earlier, the Houston, Texas, VAMC has one of the most overworked SCI Centers in the Nation, and there is a demand there for the establishment of a long-term care SCI facility. This facility, should it be constructed, would accomplish two things: first, it would provide expanded services and facilities for certain SCI veterans and, second, it would remove some of the burden now being placed on the Houston SCI Center by SCI veterans who could be amply cared for in less expensive but even more appropriate long-term care facilities.

IV. COST-SAVINGS-SUPPLEMENTS TO CONSTRUCTION AIMED AT CARING FOR SCI VETERANS

PVA believes, based upon our on-going observations, that SCI veterans can sometimes have their health-care needs met through improved VA services which would be more cost effective than are certain aspects of the presently-employed means of caring for veterans. We will briefly outline them below, recognizing that should Congress have an interest in taking them through to fruition there will likely be need for in-depth documentation.

First, PVA urges that consideration be given to the establishment of additional satellite clinics for out-patient treatment. This recommendation is based upon the earlier-mentioned three such clinics which exist within the VA, clinics which have proven themselves capable of meeting many needs of SCI veterans in a timely and inexpensive manner. Furthermore, in thinly settled areas of the Nation, such clinics could save veterans (and the VA) travel costs, and SCI veterans would not have to undergo the rigors of lengthy travel in order to receive treatment for relatively minor difficulties.

These satellite clinics could possibly be co-located with Department of Defense installations or stations under the proposed VA-DOD Sharing

Agreements, which are to be implemented. In instances such as these, the use of DOD-supplied resources such as space, medical, diagnostic or treatment equipment, maintenance, and transportation could be utilized by teams of VA health-care personnel who would examine and treat the patients. Combinations of physicians, registered nurses, rehabilitation therapists, and others could provide traveling teams to visit designated locations at specific intervals. PVA supports this concept and asks that the VA conduct further studies of its feasibility.

Second, PVA believes an expansion of the Hospital Based Home Care program would significantly improve the VA's capability of delivering high quality care to aging SCI veterans. PVA has a number of members who have utilized this program to improve their quality of living. Every consideration should be given to placing eligible veterans in this program.

Third, PVA supports extending the Fee Basis Home Health Care Program, because it is cost effective and it allows catastrophically disabled veterans to maintain a viable home environment in their community. The result is greater personal satisfaction for such veterans and less cost to the VA.

V. STREAMLINE VA CONSTRUCTION PROCEDURES

Mr. Chairman and Members of the Subcommittee, PVA has witnessed needless duplications whenever the VA has constructed health-care facilities, duplications of effort within the VA which add to the construction costs of VA facilities. And, we have seen internal conflicts which have resulted in delays, such as when the VA considered purchasing land adjacent to the Tampa, Florida, VA Medical Center. In short, we think that VA construction procedures could be streamlined to the benefit of the government, of taxpayers, and of veterans.

Maintaining a separate Office of Construction within the VA seems like a needless duplication, especially since approximately 90 percent of the work done by the Office of Construction is for the Department of Medicine and Surgery. Furthermore, these two departments within the VA often have differing or conflicting goals and views, complications which make construction more costly than it need be. A dichotomy exists within the structure of the VA, where the Chief Medical Director bases construction needs, criteria, and timetables on the assessment of existing and future patient requirements, but the Office of Construction bases construction needs and timetables predicated on existing and projected budget considerations, only.

The Chief Medical Director is more capable of judging patients' needs, as he is more capable of determining what facilities should be designed in a particular manner so that they will be optimally functional for VA health-care professionals who must work in these facilities caring for patients.

Furthermore, the Chief Medical Director already must consider budget matters as he looks toward accomplishing his mission; therefore, it is not as if he would act irresponsibly should construction be placed under his control. It would simply mean that the same individual could evaluate a number of considerations and implement medical care and construction planning with less conflict and fewer delays, and an often incongruous coordination step could be eliminated.

PVA feels that the Office of Construction should be placed within the Department of Medicine and Surgery, under the supervision of the Chief Medical Director. Then, construction would be an integrated part of the VA medical system and there would be fewer disruptions and less opportunity for veterans to be caught in conflicts which now arise as separate branches of the Veterans Administration disagree over ways to care for their needs. The most readily apparent example of this conflict which harms veterans needlessly is the still-pending long-term care SCI facility which should already have been built at Hines VA Hospital but which the Office of Construction has delayed while construction costs continue to rise.

A second consideration, whether the Office of Construction is made part of the Department of Medicine and Surgery or remains a separate branch of the VA, is that there needs to be more direct coordination between the VA Central Office and local VA personnel, whenever a construction project is undertaken.

Under the present system there is a great reliance on non-VA contractors who merely tell the VA what it already knows and charge sizable sums for this unnecessary information. For example, after the Office of Construction designed the Memphis, Tennessee, VA Medical Center, it then contracted with a private firm to provide technical drawings for the facility, at considerable cost to the government. This seems senseless when capable VA employees had already designed the facility, but it was a requirement that outside sources verify the VA's computations and design criteria.

This second proposal, to curtail the use of contractors to verify information already determined by VA architects, would require that there be a department of criteria established within the VA, since it would be working directly with local builders on construction projects. In other words, the VACO would be responsible for overseeing local projects, and the VA must be certain that local projects meet criteria established initially.

VI. CONCLUSION

Mr. Chairman and Members of the Subcommittee, PVA appreciates your continuing interest in and concern for the construction of VA facilities. PVA shares your concerns that costs are so great, but we, like you, recognize that veterans' medical and health-care needs require attention since illness has no regard for money. PVA has attempted to show reasonable ways that the entire VA health-care system would benefit, such as earliest possible completion of the needs assessment studies and inclusion of VA facilities as part of the federal infrastructure to be renovated under the provisions of a restoration/employment measure. Furthermore, we have attempted to show that new SCI Centers are urgently needed at Albuquerque, New Mexico, and Dallas, Texas, and long-term care facilities for SCI veterans must be built at Tampa, Florida, and Hines VA Hospital in Chicago, Illinois, if the needs of older veterans are to be met. At the same time PVA has attempted to offer suggestions for ways to meet many SCI veterans' medical and health-care needs without additional construction projects, and we feel that satellite out-patient clinics and amendment of certain existing programs such as Hospital Based Home Care and Fee Basis Home Health Care could do much to provide needed services conveniently and cost effectively for SCI veterans who reside in thinly-populated areas of the Nation. Finally, PVA feels that less duplication of effort within the VA as it approaches construction projects would produce facilities more quickly and at less cost to the government.

I trust that PVA's observations and suggestions are of value to you as you consider the VA's construction program, and the members of PVA hope that you will be supportive of our efforts to have needed additions made to an already overworked VA SCI program. This concludes my comments and I will be glad to answer any questions that I can.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DONALD H. SCHWAB, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

WITH RESPECT TO THE VETERANS ADMINISTRATION FISCAL YEAR
1983 - 1987 FIVE YEAR MEDICAL FACILITY CONSTRUCTION PLAN

WASHINGTON, D. C. DECEMBER 14, 1982

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the privilege of appearing before this distinguished Subcommittee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab, and it is my privilege to serve the more than 1.9 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

Mr. Chairman, 38 USC 5004 requires approval by both the Senate and House Veterans' Affairs Committees for construction projects within the Veterans Administration costing more than $2 million or annual leases exceeding $500,000.

The Administrator of Veterans Affairs is required by 38 USC 5007 to annually submit to the Veterans' Affairs Committee of both houses a five year plan for the construction, replacement or alteration of those medical facilities that, in the judgment of the Administrator, are most in need of construction including a list, in order of priority, of not less than 10 hospitals.

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N. E. ● WASHINGTON, D. C. 20002 ● AREA CODE 202-543-2239

The current VA Fiscal Year 1983 - 1987 Construction Plan is dated June 1982 and lists the 10 medical centers most in need of construction, replacement or major modernization as follows: (1) Minneapolis, Minnesota; (2) Houston, Texas; (3) Allen Park, Michigan; (4) Albuquerque, New Mexico; (5) Mountain Home, Tennessee; (6) Pittsburgh (Aspinwall Division), Pennsylvania; (7) Augusta (Lenwood Division), Georgia; (8) Biloxi, Mississippi; (9) Gainesville, Florida; and (10) Baltimore Metropolitan Area.

Although the Administrator has complied with the above cited provision of the law, the priority list is of questionable value at this time due to the Administrator's revalidation of all construction projects planned for the Fiscal Year 1984 and the out years as announced in his news release dated February 19, 1982. Notwithstanding the fact that the Director of our VFW National Veterans Service is a member of the Administrator's Facility Planning and Construction Committee (FPCC), we do not at this time know which projects have been revalidated other than the replacement hospital at Minneapolis, Minnesota. We have been advised that of the 57 projects to be funded in the Fiscal Year 1984, 35 have been revalidated, 21 deferred and one canceled. Therefore, not knowing which projects fall into which category, it is not possible to intelligently discuss the Five Year Construction Plan. Members of the FPCC were advised the revalidation would be completed by September and, following approval by the Office of Management and Budget, released to Congress and the veterans' organizations. We now understand this information has been embargoed as a budget matter by OMB.

By letter dated June 7, 1982, the Administrator wrote to the Chairman of the full Committee, the Honorable G. V. (Sonny) Montgomery, advising him that the replacement medical center at Minneapolis, Minnesota had been revalidated and, "would result in an 845 bed hospital (725 accute beds; 120 nursing home care beds) appropriately sized and configured to operate as an effective, modern tertiary care medical facility." However, we hear reports that the Office of Management and Budget would still like to reduce this facility to a 645 bed hospital consisting of 525 hospital beds and 120 nursing home care beds. You will recall that the Local Health Systems Agency pressed for down sizing the Minneapolis replacement facility because this same agency had authorized the over building and over bedding of community hospitals. Unfortunately, the Administrator added fuel to this controvery and performed a disservice to veterans when he was quoted by the Associated Press as asking, "Does it make sense to spend $280 million for a replacement hospital in Minneapolis where we've got 2,000 empty beds already and where you've got a declining veteran population?" We surely hope that reducing the size of the replacement facility at Minneapolis is a moot issue and the rumblings we hear are not correct. Very few VA medical centers have been more scrutinized or more fully justified than the 845 bed replacement facility at Minneapolis. We trust that construction funding for Minneapolis will be included in the VA Fiscal Year 1984 request since the Minneapolis project has been listed as the number one priority since 1980. In the House passed HUD-Independent Agencies appropriation measure for 1983, $260 million was included to fund this construction which was stricken by the Senate and deleted by conferees from the appropriation because a VA representative responding to questioning before this very Subcommittee last April stated, "We could not use the construction money in Fiscal Year 1983. The money would have just sat idle. Therefore, we didn't think it prudent to request construction money at that time." However, we acknowledge that the VA has been using the $15 million appropriated in 1981 for architectural engineering designs and other construction preparation purposes. We are advised $3.4 million has been contracted for the construction of a temporary clinical facility.

Quite naturally, Mr. Chairman, we are deeply concerned with the reported cancellation of one project and the deferral of 21 others, particularly if hospitals or nursing home care facilities are included. What project was canceled and what was the rationale for such cancellation? Which projects were deferred and why? We are all aware that deferrals escalate the cost of construction and repeated deferrals ultimately result in cancellation of the project since it becomes fiscally unpalatable. In 1972, an 811 bed replacement hospital was completed in San Diego, California at a cost of $40.3 million. In 1977, an 820 bed hospital at Los Angeles, California was completed at a cost of $87 million. We are now speaking in terms of some $280 million for an 845 bed facility at Minneapolis.

Mr. Chairman, one of the recommendations of the General Accounting Office report of last December entitled, "Opportunity to Reduce the Cost of Building VA Medical Facilities," was that the construction time of VA facilities could be reduced by as much as 15 months and cost by perhaps 11.6 percent by extending the Advance Planning Fund to allow the VA to contract for final designs while Congress reviews projects. As stated in my testimony on this same subject last April, this suggestion by GAO is worthy of serious consideration. Subsequently, I have been advised that extending the Advance Planning Fund would require legislative action and if this be the case, appropriate action should be taken by this Subcommittee.

Mr. Chairman, although the Advance Planning Fund (APF) is a line item in the VA budget, it is an item to which we have perhaps paid too little attention. For the Fiscal Year 1983 the VA needed $5 million more for this fund than it received. If the APF is cut below the amount required, construction is delayed proportionately since, obviously, construction cannot be commenced without proper plans. This is an easy fund for budget cutters to zero in on since it cannot readily be identified as delaying a specific construction project.

Mr. Chairman, the concern of the VFW is that adequate and timely funding be appropriated for hospital, nursing home care and domiciliary construction to meet the continuing needs of our veteran population. Maintaining the integrity of the VA hospital and medical care system is our first priority.

You will find appended to my testimony the following resolutions passed by the voting delegates to our last National Convention specifically addressing the VA construction program:

Resolution No. 616 - "VA Construction Program"

Resolution No. 679 - "Replacement of Veterans Administration Medical Center, Allen Park, Michigan"

Resolution No. 715 - "New Construction - VA Medical Center, Houston, Texas"

This concludes my testimony, Mr. Chairman, and I will be happy to respond to any questions you may have.

Thank you.

Resolution No. 616

VA CONSTRUCTION PROGRAM

WHEREAS, the Administrator of Veterans Affairs has ordered a revalidation of all major construction projects planned for 1984 and beyond on the premise that there presently is no defensible criteria by which all Veterans Administration Construction Projects can be justified; and

WHEREAS, while the Veterans of Foreign Wars of the United States supports any responsible effort to strengthen the criteria by which all VA construction projects are established in order that they may be justified before Congress, we do not totally agree with the Administrator of Veterans Affairs that there presently is no defensible criteria since the construction projects on the present five-year VA medical facility construction plan have been scrutinized at all levels from the medical facility through the district, regional and central office validation process, to include: medical facility five-year plan and long range comprehensive facility plan, medical district and regional directors project prioritization process, technical evaluation process, Space and Functional Deficiency Identification System (SFDI) evaluation, National Bureau of Standards System, National Fire Protection Association Life Safety Code, Joint Commission of Accreditation of Hospitals requirements, demographic data and Presidential Guidance, among other criteria; and

WHEREAS, all medical facility construction projects must subsequently pass the acid test of both the Office of Management and Budget and Congress; and

WHEREAS, this organization is vitally concerned that this "revalidation" process not be used as a subterfuge for the suspension or further reduction of critically needed medical facility construction projects; now, therefore

BE IT RESOLVED, by the 83rd National Convention of the Veterans of Foreign Wars of the United States, that notwithstanding our qualified support of this revalidation process we will oppose indiscriminate curtailments, delays, reprioritizations or suspension of construction projects for medical centers considered most in need of replacement or modernization as has been previously, or may be in the future, identified.

Adopted by the 83rd National Convention of the Veterans of Foreign Wars of the United States held in Los Angeles, California, August 13-19, 1982.

Resolution No. 616

Resolution No. 679

REPLACEMENT OF VETERANS ADMINISTRATION MEDICAL CENTER, ALLEN PARK, MICHIGAN

WHEREAS, for the past fifteen years, the Department of Michigan, Veterans of Foreign Wars of the United States, has made attempts to have the Veterans Administration Medical Center, Allen Park, Michigan, replaced with a new facility; and

WHEREAS, Veterans of Foreign Wars' hospital surveys conducted in February, 1975 and again in February, 1978, revealed findings that justified an early replacement of the Allen Park facility and further, the VFW conclusions were confirmed by a special study (identified as the Rossetti Report) which was conducted on orders from the Congress of the United States, and the hospital should be replaced; and

WHEREAS, in compliance with Public Law 96-22, Section 5007, the Veterans Administration has announced a list of ten hospitals most in need of construction, replacement, or major modernization, and Allen Park is ranked number six; and

WHEREAS, in response, the VA is now engaged in a comprehensive study of this facility, but it is fearful that an effort will be made to modernize this station to save construction dollars over the next five years without regard for the fact that the Allen Park Hospital has built-in deficiencies that cannot be corrected; and

WHEREAS, over a period of time from a cost effectiveness aspect, it would cost the VA more to operate this hospital than it would to build a new medical center adjacent to Wayne State School of Medicine; now, therefore

BE IT RESOLVED, by the 83rd National Convention of the Veterans of Foreign Wars of the United States, that the Administrator of Veterans Affairs be urged to seek funds for the replacement of the Allen Park Veterans Administration Medical Center to be constructed adjacent to the Wayne State School of Medicine, Detroit, Michigan; and

BE IT FURTHER RESOLVED, that the Allen Park Veterans Administration Medical Center not be closed after the new hospital becomes operational but be used for treatment of psychiatric disorders, intermediate care, nursing care patients, and domiciliary care.

Adopted by the 83rd National Convention of the Veterans of Foreign Wars of the United States held in Los Angeles, California, August 13-19, 1982.

Resolution No. 679

Resolution No. 715

NEW CONSTRUCTION VA MEDICAL CENTER HOUSTON, TEXAS

WHEREAS, a grateful Congress has seen fit to approve a new Veterans Hospital in Houston, Texas; and

WHEREAS, construction of this hospital was to begin in fiscal year 1984; and

WHEREAS, there has been many hours of planning and monies invested in the preparations of building a new hospital that would save lives and money in the future; and

WHEREAS, we do not feel that one man (the head of an agency) has the right to cancel what our grateful Government has already granted; and

WHEREAS, it is our belief that The Administrator of the Veterans Administration does not have the experience in the veterans benefits programs or the medical needs to make such snap judgments; and

WHEREAS, the majority of veterans that are moving to another locale are moving to the Houston area; now, therefore

BE IT RESOLVED, by the 83rd National Convention of the Veterans of Foreign Wars of the United States, that we strongly oppose the recommendations of the Administrator of the Veterans Administration, and strongly urge that the Congress of the United States see to it that a new hospital be built in Houston, Texas as previously planned.

Adopted by the 83rd National Convention of the Veterans of Foreign Wars of the United States held in Los Angeles, California, August 13-19, 1982.

Resolution No. 715

TESTIMONY OF GABRIEL P. BRINSKY

AMVETS National Service & Legislative Director

Before The
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

Of The
COMMITTEE ON VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

December 8, 1982

The Veterans Administration medical health care system which was built after World War I was intended to take care of four million veterans. Today, with 26 additional millions of veterans and 172 VA hospitals with 225 clinics, the health care provided our veterans is different. Thanks to General Omar Bradley's wisdom in affiliating the hospitals with universities after World War II and the foresight of the planners and the Members of Congress the VA health care system is so much different that there is none like it. It has no counterpart in socio-empathy, cost effectiveness, or quality.

In February 1982, the Administrator of the Veterans Administration established a VA facility planning and construction Commission (FPACC) to serve as a steering committee for revalidation of future construction projects as well as to renew policy options and to analyze planning and construction procedures. As a result of the revalidation process, of the 57 projects reviewed, 35 were revalidated with the remaining 22, 1 canceled and 21 deferred from fiscal year '84 construction consideration either due to design delays or the necessity to redesign the project to reflect a better project scope.

As the Committee is aware, every VA hospital is required to maintain a 5-year plan which is reviewed and approved or modified by the VA Central Office. The overall 5-year plan for renovation and replacement is then submitted to the House and Senate Veterans Affairs Committees for their review. It is once again reviewed by the Appropriations Committees of both the House and Senate. And it would appear that this procedure is extensive enough to ensure that approved construction projects are needed and wanted. To add further assurances, if this were possible, the Chief Medical Director initiated a Medical District Initiative Program Planning (MDIPP) process which should assist to cure any deficiencies which may currently exist. This process will first impact in fiscal year 1985 or later on the construction program.

In spite of these protracted procedures on hospital construction planning, the program continues to come under attack primarily from the civilian sector. We are concerned about these attacks. At one time, there were as many as 121 thousand beds and recently we had only 85 thousand beds with a daily census that averaged less than 70 thousand. Yet our veteran population has grown to 30 million. Fortunately, Congress has seen fit to place a floor of 90 thousand beds with the enactment of recent legislation.

The various local health planning service groups oppose VA hospital construction. They are concerned with their 130 thousand empty beds, a matter completely unrelated to the health care needs of the veteran and a situation created entirely within the private sector. But there are those who would erode the system entirely by placing the veterans in these empty beds in the private sector and have them treated by private physicians paid for by the Veterans Administration.

What causes us some anxiety is that the arguments for a "vouchering system" and "mainstreaming", first raised many years ago and apparently then dismissed, is gaining advocates and new support. The 1977 Report of the National Academy of Sciences entitled "Health Care For American Veterans" recommended that the VA system be phased into the general delivery of health services in the community now seems to be taking on new dimensions.

We touch on all these matters in greater detail in our statement. We would like to conclude however on making three brief observations. First, to those in the private sector who argue that new construction of facilities is battling their attempts to contain empty beds and hospital costs, it should be noted that the entire construction program of the VA for all intents and purposes is for renovation, replacement or correction of deficiencies. There is no "new" construction as such.

Secondly, under Public Law 97-174, the Veterans Administration and the Department of Defense are required to share medical facilities. The Veterans Administration will serve as the contingency backup for the Department of Defense in the event of an emergency.

And lastly, we are faced with a rapidly aging veteran population. In eight years from now veterans 65 years or older will more than double from the present 3,600,000 to 7,600,000.

In this framework, one might reasonably raise the query as to whether the VA medical construction program is not in fact too conservative?

In 1973, Public Law 93-82 was enacted which mandated the National Academy of Sciences to conduct a study and make recommendations to the Congress and the Veterans Administration regarding staffing and other resources required for the VA health care system to deliver quality health care to our veterans. The study which took four years and required an expenditure of more than $7 million, was unresponsive to the Congressional mandate. Amongst the gratituous recommendations that it made was that the VA policies and programs should be designed to permit the VA health care system to be phased gradually into the general delivery of health services in communities across the countries. While this concept may not have originated with the academy, its adoption by the academy now imbued it with an official aura of some prestige which could very conventiently be bounced upon by the Office of Management and Budget in its attempt to erode the health care system.

We have seen the beds in our VA hospitals decrease from 121 thousand to 85 thousand. Once the daily patient census was 114 thousand, it became less than 70 thousand. And while this was occurring, our veteran population was increasing and the need for medical attention was expanding. True, as claimed by the Administration, the shortening of the patients' length of stay might have assisted in the reduction of beds, there is no question that it is by reason of the activity of the Office of Management and Budget in denying or limiting health care services to nonservice-connected veterans that this decrease has occurred. This in spite of the fact that the Congress has been most generous in responding to request for funds through increased appropriations for medical care.

The opponents of the VA health care system refer to "new" construction program of the VA. The fact is that a new VA hospital has not been constructed in years. Included in the 172 hospitals are some which were built before World War II. A number of them were constructed immediately following World War II. A number of them are more than 30 years old. The configuration demanded by modern medical technology has aged many more of them.

As this Committee is aware, every VA hospital is required to maintain a 5-year plan which is reviewed and approved or modified by the VA Central Office. The 5-year plan calls for renovation and replacement which is then submitted to the House and Senate Veterans Affairs Committees for review and approval or modification. This plan is also reviewed by the Appropriations Committees of both the House and Senate. Considering this exhaustive process,it has always been the position of AMVETS that the methodology and the extensive studies conducted by the Veterans Administration together with the Congressional reviews that the decisions which result therefrom are predicated upon thorough analysis and consideration. An additional input into this process will begin sometime around fiscal year 1985 when the Medical District Initiative Program Planning (MDIPP) process will be available in planning hospital construction programs.

It would seem under the circumstances that there would not be a need as required under OMB Circular A-95 to provide state and area wide clearinghouses with an opportunity to coordinate review of proposed VA major construction projects with the appropriate Health Care Agencies, State Health Planning Agencies, and other affected agencies and to consider such agencies' views and comments. While we see no need for coordination or inextricably joining the Veterans Administration planning and construction program with the needs of the private sector, we perceive no harm in receiving their input. It is and always has been the position of AMVETS that the problem created in the civilian sector by an overage of beds currently somewhere in the neighborhood of 130 thousand was not the responsibility of or the obligation of the Veterans Administration. Our health care requirements are different and so are our needs. The Veterans Administration facilities are not confined to the treatment of patients within defined districts but draw upon many jurisdictions.

The local health care planners, of course, are interested in solving their overage of empty beds. They wish to "mainline" VA medical care by placing the veterans in those beds. They would like to have the VA pay the private doctors who take care of them in those beds through a vouchering system. These advocates contend that the obligation to veterans is to provide care, not to provide care in a facility which is too costly, unnecessary and duplicative. It is also argued that at a time when everything is being done to keep the number of beds down, the VA is building beds.

The fallacies in these arguments have been noted. The number of beds in the VA health care system have been decreasing. Its population has been increasing. There has been no new construction of VA facilities in recent years. But it is not just that simple in determining how many beds are available. It is of paramount importance to know in addition what kind of beds are available and where they are located. Beds in obstretrics and pediatric sections or beds in hospitals inconvenient to areas' serving veterans are of little value.

Mr. Chairman, as we have testified on many occasions in the past, we are greatly concerned about geriatrics and the aging veteran. We continue to be of the opinion that the VA geriatrics research, education and clinical centers, of which there are eight, are insufficient. We were greatly disappointed when the Camden Hospital was canceled as a project. We appreciate the efforts which are being made at these eight centers to attract and to develop a staff in the field of gerontology and geriatrics and the attempts being made to advance and integrate research and educational achievement in geriatrics and gerontology into the VA health care system. We do not believe that this is sufficient to serve the need that we see in the horizon. The VA has been authorized by legislation to designate 15 health care facilities as GRECC'S and we realize that the Congress has withheld funding for more than 8 of the centers currently in operation. But we continue to feel that we need an advocate in the Veterans Administration, which after all, is charged with the responsibility of taking care of our aging veterans. We feel that this Committee should encourage the Veterans Administration to do just that, namely, to encourage its adventure into geriatric research and education. I will not bore the Committee with a lot of statistics. I would just merely like to make a point that the projected veteran population of 65 years and older is on an ever increasing path and will reach its maximum in less than 20 years.

While perhaps a little peripheral to the question of the VA funding and construction program, AMVETS feels that because of its extreme importance some comment should be made on the role played by the State Veterans Homes. There are states that furnish domiciliary, nursing home or hospital care in their facilities to veterans eligible for VA care. We, in AMVETS, have always viewed this as a vital and important link in the administration of a common program shared by federal and state. The VA relationship is established either by a per diem program which assist the state in providing care to eligible veterans and another program which provides assistance with the funding of construction, remodeling or alteration of state veterans facilities.

From past experiences, the veterans generally treated in the state veterans nursing home and domiciliaries were older than their peers treated in the VA facilities. There was a greater number of veterans age 65 years or older in the state facilities.

The contribution made by the state veterans homes which maintain an average daily patient census of more than 10,000 in their nursing home, domiciliary and hospitals, may be a limited contribution viewed in terms of the over-all veteran population. Yet, it is extremely important to the VA extended health care program. It augments resources available through the limited facilities and funding available to the Federal Government.

We encourage the assistance of states in providing these facilities for the veterans who served. We believe that this is a proper role for the states. We believe that the Federal Government should assist them in performing this function without whose aid they could not carry on this important mission.

In conclusion, the opponents of the VA health care system who contend that it is too costly, unnecessary, and duplicative are wrong. More important, they are losing sight of the important factor of empathy. A veteran feels that he belongs in a VA hospital and he will be losing that identity in a private hospital. Hopefully, the Congress will never permit this to occur.

This concludes my testimony. Thank you.

TESTIMONY OF CONGRESSMAN BRUCE F. VENTO

Before the

HOUSE VETERANS AFFAIRS COMMITTEE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

December 14, 1982

Mr. Chairman:

On April 1, 1982, I had the pleasure of testifying before your Subcommittee in support of the Veterans Administration Medical Construction Program and the construction of the replacement VA Hospital in Minneapolis, Minnesota. At that time, I emphasized the inadequacy of the present hospital and the need for the construction of a replacement facility at the earliest possible date. I also emphasized that this project had been subject to the strictest scrutiny during months of study before Congress approved funding for this project in 1980. Today, in light of recent developments which have come to my attention, I must reiterate the importance of proceeding without delay on this project.

It has come to my attention that the Office of Management and Budget (OMB) will propose a reduction in the total number of acute care beds at the Minneapolis replacement VA hospital, from 725 to 525. The Office of Management and Budget has not yet made this recommendation completely public; neither has it denied that it has decided to take this action. If it is true, however, that OMB is going to recommend a 200 bed reduction in the acute care unit, they will be resurrecting an issue that was supposedly settled months ago. After coming into office in January, 1981, the Reagan Administration and the President's VA Administrator, Mr. Robert Nimmo, reassessed and reapproved the construction of a replacement VA hospital in Minneapolis and again identified this project as its top priority construction project in 1981. A series of continuous delays over the past two years, however, have resulted in needless increases in the cost of this project and have been detrimental to the interests of veterans and the public at large. Another delay at this late date would be unconscionable.

The Minneapolis VA hospital is one of the most active in the VA system. The education and medical research programs are the largest in the country. Currently, the Minneapolis VA hospital handles in excess of 225,000 outpatients and over 19,000 inpatients annually. This facility not only serves a large veteran population living in the Minneapolis-St. Paul metropolitan area, but serves a combined veteran population of over 800,000 people in Minnesota, Wisconsin, North Dakota, South Dakota and Iowa.

Past VA studies have shown that as the veteran population grows older, there is a corresponding increase in the demand for medical care at VA hospitals. The number of veterans who are 65 years or older in the Twin Cities metropolitan area alone is expected to increase approximately 142 percent between 1980 and 1990, from 54,040 to 127,330. A similar dramatic increase in the age of the veteran population in the Upper Midwest region is also expected to occur during this ten year period as our World War II and Korean veterans reach retirement age. Any assessment concerning the number of acute care beds that will be needed in the new Minneapolis VA hospital must recognize these facts. While there may have been some underutilization of beds in recent months, there is no reason to expect this situation to prevail in the future. Furthermore, any underutilization of beds may be due to economic and administrative factors rather than to choice by veterans to use other private or public hospitals to serve their acute health care needs. Staff reductions influence admissions and occupancy figures just as surely as decisions to seek treatment in alternative health care facilities outside the VA system.

The Congress carefully considered these factors when it approved the appropriation for the construction of the new Minneapolis VA hospital. To permit OMB to re-open this issue at this late date and to substitute its judgment for the carefully reasoned judgment of our elected representatives would be grossly unfair to thousands of veterans and their families who have looked to Congress for leadership on this important issue. I urge you to stand behind the sound decision which was made over two years ago; to build a hospital which will provide quality health care and will serve the future needs of an aging veteran population. Thank you.

MARCH 1982

LIST OF MAJOR CONSTRUCTION PROJECTS FOR REVIEW - FY 84

KEY:

* Projects Audited by IG

+ Already Funded for Design

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	ESTIMATED PRELIMINARY DESIGN COMPLETION AS OF 3/5/82	ESIMATED REMAINING COST ($000) AS OF 3/5/82
Alexandria, LA	3	502-058	Clinical Improvements & Relocate Support Function	6/82	$ 30,000
Amarillo, TX	6	504-026	Addn./Renov. Clinical Support	6/81	$ 44,000
Bath, NY	1	514-068	Renovate Bldg. 78 for NHC	12/80	$ 7,200
Battle Creek, MI	4	515-083	Renovate Bldg. 82 (First & Second Floors - Patient Privacy)	2/82	$ 5,800
Beckley, WVA	2	517-013	Clinical Addition & Alterations	10/80	$ 25,000 *
Biloxi, MS	3	520-056	Modernize Various Buildings (BD and GD)	9/82	$ 87,300
Brockton, MA	1	525-016a	Modernize Buildings #2 & #7	8/79	$ 29,500
Brockton, MA	1	525-021	Addition & Renovation for SCI	6/82	$ 6,800
Buffalo, NY	1	528-039	Res. & Education Facility	3/81	$ 27,400 *
Castle Point, NY	1	533-056	Building Addition	5/81	$ 15,000
Charleston, SC	3	534-015	Clinical Addition	4/82	$ 20,000
Cheyenne, WY	5	442-023	Expand/Renovate Bldg. #1 (Clinical Function)	11/82	$ 7,700

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	ESTIMATED PRELIMINARY DESIGN COMPLETION AS OF 3/5/82	ESTIMATED REMAINING COST ($000) AS OF 3/5/82
Chicago (Westside), IL	4	537-024	OPC Addition/Renovation Bldgs. #11a & #11b	1/82	$ 40,500
Cincinnati, OH	4	539-026	Upgrade Electrical Distribution	3/82	$ 3,000
Clarksburg, WV	2	540-008	Clinical Addition & Alterations	12/82	$ 15,000
Cleveland, OH	4	541-021	Clinical Improvements (Surgical Service Relocation)	4/82	$ 15,000
Durham, NC	2	558-025	Additional Elevators	12/81	$ 4,300
East Orange, NJ	2	561-034	Relocation/Consol. Res.	10/82	$ 5,300
East Orange, NJ	2	561-035	120-Bed NHCU	2/83	$ 15,000
Fayetteville, NC	2	565-027	Clinical Addition	4/82	$ 15,800 *
Fresno, CA	6	570-019	Clinical Addition (Dental, Surgical, RMS, etc.)	11/82	$ 10,000
Hines, IL	4	578-096	New Warehouse/Service Building	10/81	$ 11,000 *
Hines, IL	4	578-097	HVAC Bldgs. #50, #51 & #53	2/82	$ 44,000
Hot Springs, SD	5	579-040	Clinical Addition	8/80	$ 14,700 *
Lake City, FL	3	594-036	Outpatient & Clinical Addition	8/82	$ 6,000
Leavenworth, KS	5	686-062	Fire & Safety Improvements (Exit & Sprinklers)	3/82	$ 7,500
Leavenworth, KS	5	686-060	208-Bed Domiciliary	7/81	$ 14,900 *
Livermore, CA	6	599-054	Fire & Safety Improvements	7/82	$ 3,500
Loma Linda, CA	6	605-004	60-Bed NHCU	10/82	$ 6,000

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	ESTIMATED PRELIMINARY DESIGN COMPLETION AS OF 3/5/82	ESTIMATED REMAINING COST ($000) AS OF 3/5/82
Los Angeles (WAD), CA	6	691-090	Renovate Bldgs. #212, #214, & #217 for DOM	9/81	$ 17,300
Los Angeles (WAD), CA	6	691-098	120-Bed NHC (Conversion) Bldg. #213 (Phase II)	3/82	$ 10,500
Lyons, NJ	2	604-064	120-Bed NHCU	8/82	$ 18,200
Manchester, NH	1	608-014	Laundry, Warehouse, Engineering Facility	10/82	$ 10,000
Martinez, CA	6	612-018	120-Bed NHCU	6/82	$ 14,400
Miami, FL	3	546-014	120-Bed NHCU	8/82	$ 16,000
+* Minneapolis, MN	5	615-001	Replace Hospital Buildings	6/82	$ 267,000 *
Montgomery, AL	3	619-020	Outpatient Clinic Addition	9/80	$ 18,100
Newington, CT	1	627-032	Addition to Bldgs. #1 & #2	4/80	$ 45,000
New York, NY	1	630-025	Upgrade Electrical Distribution, Phase II	10/78	$ 4,000
Northport, NY	1	632-062	120-Bed NHCU	9/82	$ 13,800
* Omaha, NE	5	636-022	Outpatient Clinic Addition	9/80	$ 24,200 *
Perry Point, MD	2	641-079	New Laundry Building	8/82	$ 18,500
+ Pittsburgh, PA (UD)	2	646-024	Outpatient Clinic Addition	2/82	$ 22,680
Pittsburgh, PA (HD)	2	645-017	Laundry	10/82	$ 12,000
Pittsburgh, PA (UD)	2	646-025	Centralized Warehouse Facility	10/82	$ 4,200
* Prescott, AZ	6	649-047	200-Bed DOM/60-Bed NHCU	3/81	$ 30,000 *

MEDICAL CENTER	MEDICAL REGION	PROJECT ID	PROJECT TITLE	ESTIMATED PRELIMINARY DESIGN COMPLETION AS OF 3/5/82	ESTIMATED REMAINING COST ($000) AS OF 3/5/82
Providence, RI	1	650-025	60-Bed NHCU	10/82	$ 6,500
Richmond, VA	2	651-003	Automated Transport System	5/78	$ 4,200
Roseburg, OR	6	653-027	Outpatient Clinic Addition	2/82	$ 28,000
+ Salem, VA	2	658-038	Renovate Bldg. #76 (Intermed)	4/77	$ 5,510
San Antonio, TX	5	671-009	Supply Warehouse & SPD	6/79	$ 5,800
San Diego, CA	6	664-028	Emergency Generator and Conservation of Energy	8/79	$ 2,800
San Francisco, CA	6	662-043	120-Bed NHCU & Parking	6/82	$ 14,400
* Sioux Falls, SD	5	438-020	Clinical & Support Service	10/82	$ 21,000 *
Syracuse, NY	1	670-016	Fire & Safety Improvements, Patient Privacy	5/81	$ 12,000
Tomah, WI	4	676-031	Modernize Bldgs. #406 & #408	9/82	$ 5,400
Waco, TX	5	685-041	Construction - New Dietetic Bldg.	3/81	$ 8,400
				57 PROJECTS TOTAL:	$ 1,197,000

LIST OF THE 35 PROJECTS FOUND READY FOR CONSIDERATION

DECEMBER 1982

VA Medical Center	Project Title	Current Estimated Cost (in 000s)
BATH, NY	RENOVATE BLDG. NO. 78 FOR NURSING HOME CARE UNIT	$ 7,000
BATTLE CREEK, MI	RENOVATE BLDG. NO. 82	3,800
BILOXI, MS	MODERNIZE VARIOUS BUILDINGS (GULFPORT & BILOXI DIVISIONS)	78,800 (88.5 TOTAL)
BROCKTON, MA	MODERNIZE BLDGS. NOS. 2 & 7	24,000
CASTLE POINT, NY	BUILDING ADDITION	8,000
CHARLESTON, SC	CLINICAL ADDITION AND RENOVATION OF EXISTING SERVICES	12,900
CHICAGO (WESTSIDE), IL	OUTPATIENT ADDITION AND RENOVATION OF BLDGS NOS. 11A & 11B	36,100 (40.6 TOTAL)
CINCINNATI, OH	UPGRADE ELECTRICAL DISTRIBUTION	3,500
CLEVELAND (WADE PARK), OH	CLINICAL IMPROVEMENTS AND RELOCATION OF SURGICAL SERVICE	9,400
DURHAM, NC	THREE ADDITIONAL ELEVATORS, TRASH AND LINEN CHUTES (Old: Additional Elevators)	3,000
EAST ORANGE, NJ	RELOCATE/CONSOLIDATE RESEARCH AND EXPAND CLINICAL LABORATORIES	3,800
FAYETTEVILLE, NC	CLINICAL ADDITION	22,000
HINES, IL	NEW WAREHOUSE/SERVICE BUILDING	11,000
LAKE CITY, FL	OUTPATIENT AND CLINICAL ADDITION	5,200
LEAVENWORTH, KS	FIRE & SAFETY IMPROVEMENTS FOR BLDGS NOS. 88-91 AND 122; PATIENT PRIVACY IMPROVEMENTS FOR BLDG. NO. 90 (Old: Fire and Safety Improvements)	9,600
LIVERMORE, CA	FIRE AND SAFETY IMPROVEMENTS; ADDITIONAL SERVICE ELEVATOR	6,500

VA Medical Center	Project Title	Current Estimated Cost (in 000s)
LOMA LINDA, CA	60-BED NURSING HOME CARE UNIT	$ 4,500
LYONS, NJ	240-BED NURSING HOME CARE UNIT (Old: 120-bed Nursing Home Care Unit)	20,000
MARTINEZ, CA	120-BED NURSING HOME CARE UNIT (pending resolution of parking)	14,400
MIAMI, FL	120-BED NURSING HOME CARE UNIT	7,100
MINNEAPOLIS, MN	REPLACEMENT MEDICAL CENTER (Old: Replace Hospital Buildings)	236,000 (251.0 TOTAL)
NORTHPORT, NY	120-BED NURSING HOME CARE UNIT	8,200
OMAHA, NE	OUTPATIENT ADDITION	26,000
PERRY POINT, MD	NEW LAUNDRY BUILDING	7,700
PITTSBURGH (HD), PA	CENTRAL LAUNDRY	6,500
PITTSBURGH (UD), PA	OUTPATIENT ADDITION	21,980 (24.5 TOTAL)
PROVIDENCE, RI	60-BED NURSING HOME CARE UNIT	5,300
SAN ANTONIO, TX	SUPPLY WAREHOUSE AND SUPPLY PROCESSING & DISTRIBUTION	4,200
SAN DIEGO, CA	EMERGENCY GENERATOR AND CONSERVATION OF ENERGY	4,200
SAN FRANCISCO, CA	120-BED NURSING HOME CARE UNIT AND PARKING	14,700
SIOUX FALLS, SD	ADDITION AND RENOVATION FOR AMBULATORY CARE, CLINICAL SERVICES, ADMINISTRATION & EDUCATION	12,800
SYRACUSE, NY	FIRE AND SAFETY, PATIENT PRIVACY AND SUPPORT SYSTEM & HVAC	32,800

VA Medical Center	Project Title	Current Estimated Cost (in 000s)
TOMAH, WI	RENOVATE BLDGS. NOS. 406 & 408	9,800
WACO, TX	NEW DIETETIC BUILDING	7,500
W. LOS ANGELES (WADSWORTH), CA	120-BED NURSING HOME CARE CONVERSION (BLDG 213)	7,500
	TOTAL COST OF 35 PROJECTS	$695,780 (727.2 TOTAL)

OVERVIEW OF THE 22 FY 1984 REVIEW PROJECTS

WHICH REQUIRE FURTHER DEVELOPMENT

DECEMBER 1982

Project Location	Original Project Scope	Reason
Alexandria, LA (Medical Region 3)	Renovate existing clinical services building & support functions & add new addition. (Project #502-058)	The Department of Medicine and Surgery had determined in Spring 1981 that the original scope and cost estimate for this project were excessive and that a more cost effective solution could be developed to meet the facility's needs which would emphasize renovation rather than new construction. The rescoping and redesign needed for this project could not be completed in time to consider the project for FY 1984.
Amarillo, TX (Medical Region 6)	Renovate & expand existing clinical services building. (Project #504-026)	The design plans received by the VA from the architect had been found unacceptable and the VA instructed the architect to submit new design plans. The architect could not complete the new design plans in time to consider the project for the FY 1984 budget.
Beckley, WV (Medical Region 2)	Construct new clinical space and renovate existing clinical space to support VA affiliation with Marshall Medical School. (Project #517-013)	This project was deferred from the FY 1984 project review at the request of the Department of Medicine and Surgery because the anticipated affiliation with the Marshall Medical School never fully materialized. The change in the facility's mission to primary care and the lack of medical school affiliation required major revisions in the project's scope and design which could not be completed in time for FY 1984 budget consideration.
Brockton, MA (Medical Region 1)	Addition of space and renovation of existing space for patient privacy and fire/safety corrections in the Spinal Cord Injury Unit. (Project #525-021)	The Department of Medicine and Surgery, with the concurrence of the Paralyzed Veterans of America, determined that in lieu of constructing additional space at Brockton, use of underutilized beds at nearby VAMC W. Roxbury would be more cost effective and efficient. The remaining scope of the project was not ready for FY 1984 consideration as additional time was needed to complete preliminary design plans and better determine the impact of these corrections on SCI bed levels at Brockton.

Project Location	Original Project Scope	Reason
Buffalo, NY (Medical Region 1)	Construbt new research and clinical treatment building. (Project #528-039)	Redesign of this project to reflect a Department of Medicine & Surgery professional review, which indicated a projected reduction in the research function and an increase in the clinical function at this Medical Center, was necessary and preliminary design plans were not ready for FY 1984 budget consideration.
Cheyenne, WY (Medical Region 5)	Renovate and expand a clinical services building. (Project #442-023)	This project was deferred from the FY 1984 project review at the request of the Department of Medicine & Surgery because of an ongoing reevaluation of the project scope and a comprehensive assessment of all of the facility's construction needs. Preliminary plans were not available for FY 1984 budget consideration.
Clarksburg, WV (Medical Region 2)	Renovate existing clinical building and construct additional clinical space. (Project #540-008)	The project was still in conceptual development and preliminary plans and a cost target were not available for FY 1984 budget consideration. Although it was recognized when the review list was formulated that the project might not be ready for FY 1984, it was included in the review because there existed an outside chance it might be ready.
East Orange, NJ (Medical Region 2)	Construct a 120-bed Nursing Home Care Unit at East Orange in addition to existing 60-bed NHC for a total of 180 beds. (Project #561-035)	As a result of the FY 1984 project review, this project has been relocated. The proposed construction site at E. Orange was smaller than ideal to accommodate the two-story layout recommended for 120-bed Nursing Home Care Units. Consequently this project has been relocated to nearby VAMC Lyons, NJ, which has an adequate construction site. However it is also recommended that 30 additional nursing home beds be achieved at East Orange by renovating an existing patient care building.
Fresno, CA (Medical Region 6)	Construct a clinical services addition. (Project #570-019)	It became evident that acceleration of this project's design would not be possible in time for FY 1984 budget consideration. Award for the initial design phase (preliminary) was made in August 1982 with completion planned for early 1983. Because design plans were not available, this project was deferred from review at the request of the Department of Medicine and Surgery.

Project Location	Original Project Scope	Reason
Hines, IL (Medical Region 4)	Renovate three existing psychiatric patient buildings at this VAMC to improve patient privacy and building mechanical systems. (Project #578-097)	Project was not ready for consideration in FY 1984 as it was necessary to determine whether it would be more cost effective to replace rather than renovate these buildings and to review new workload projections which indicate that it may only be necessary to replace or renovate two of the three buildings to meet the facility's needs. As these reviews are now being undertaken, the project was not ready to be considered for FY 1984.
Hot Springs, SD (Medical Region 5)	Construct a new clinical addition. (Project #579-040)	The Department of Medicine & Surgery requested that this project be deferred from the review in order that potential mission changes for this Medical Center could be considered in the new Medical District Initiated Program Planning (MEDIPP) process. Consequently, this project was not reviewed in order that the construction needs of this Medical Center could be better coordinated with the facility's mission.
Leavenworth, KS (Medical Region 5)	Construct a new 208-bed domiciliary. (Project #686-060)	This project was not ready in time for FY 1984 budget consideration in order to allow time for the Department of Medicine and Surgery's review and reevaluation of the mission and space criteria standards for the VA's domiciliary program to be finalized. Upon completion of this review, updated policy guidance will be issued to provide direction to the VA's domiciliary construction program.
Manchester, NH (Medical Region 1)	Construct a new laundry, warehouse and engineering building. (Project #608-014)	This project was not ready in time for FY 1984 budget consideration in order to study the feasibility of using excess laundry capacity at the VAMC Brockton, MA, in lieu of constructing a new laundry at Manchester. If use of the Brockton laundry for Manchester's needs proves feasible, the existing laundry space at Manchester could potentially be renovated to provide needed warehouse and/or engineering space for this Medical Center. The results of this study will determine the future scope of this project.

Project Location	Original Project Scope	Reason
Montgomery, AL (Medical Region 3)	Construct a new outpatient clinic addition. (Project #619-020)	As the future mission of this facility was under review by the Department of Medicine and Surgery, the project was not ready in time for FY 1984 budget consideration. The mission and subsequent construction needs of this Medical Center are being assessed by the Department. This will ensure that future construction at this facility is appropriate to meet the Medical Center's needs and mission.
Newington, CT (Medical Region 1)	Renovate existing patient wards including construction of additional space at two buildings to improve patient privacy. (Project #627-032)	This project was deferred from the review at the request of the Department of Medicine & Surgery in order that major revisions in the project's scope and space program could be evaluated. The original design plans for this project resulted in a project cost which approached the cost of total replacement. The time needed to restudy and recycle the design plans precluded the project from FY 1984 consideration.
New York, NY (Medical Region 1)	Upgrade electrical distribution needed for a new outpatient addition planned for FY 1985/1986. (Project #630-025)	This project is needed only if a future planned Outpatient Addition project at this Medical Center is constructed. As the two projects are tied together, the electrical distribution project should be funded in conjunction with the funding approval for the Outpatient Addition. The project was not included for FY 1984 budget consideration in order that this could be accomplished.
Pittsburgh, PA (Medical Region 2)	Construct a new central warehouse for the VA medical facilities in the Pittsburgh area. (Project #646-025)	The preliminary findings of an economic analysis indicated that it might be more economical to lease warehouse space for this Medical Center, rather than construct new warehouse space. The project was not ready for FY 1984 consideration as the economic analysis had to be completed, and a determination made whether adequate, cost effective space was indeed available for lease in the area. The market survey of leased space could not be completed in time for a decision to be made on this project for FY 1984.

Project Location	Original Project Scope	Reason
Prescott, AZ (Medical Region 6)	Construct a combination 200-bed domiciliary unit and a 60-bed Nursing Home Care Unit. (Project #649-047)	The domiciliary portion of this project was not considered for FY 1984 in order to allow time for the Department of Medicine and Surgery's review of the mission and space criteria for the domiciliary program to be finalized and updated policy guidance issued to direct the VA's domiciliary construction program. The 60-bed NHC Unit was not ready for FY 1984 consideration because it was designed as an integral part of the domiciliary project and could not be architecturally removed to proceed with it alone. The review process also recommended that the number of NHC beds planned for this Medical Center be increased to 120 and the NHCU be sited as a separate building. (NOTE: The Agency has since decided to proceed separately with a project for a 120-bed NHC Unit while studying the best alternative for providing domiciliary care at the Medical Center.)
Richmond, VA (Medical Region 2)	Build an automatic transport system for automatic transport of food from food preparation areas to patient areas. (Project #651-003)	The Medical Center has advised that it finds manual transportation of food to be more cost effective than automatic transfer and has requested cancellation of this project. The project was not considered for FY 1984 in order that data on the performance of the manual system could be evaluated. Project may ultimately be cancelled if study of the manual system demonstrates it is more cost effective.
Roseburg, OR (Medical Region 6)	Construct a new outpatient addition. (Project #653-027)	This project appeared overscoped for the facility's actual and projected needs and a new design concept was necessary. The project was not considered for FY 1984 because of an ongoing reevaluation of the facility's needs and the scope and cost of this project.
Salem, VA (Medical Region 2)	Renovate existing patient care building including strengthening structure for possible earthquakes. (Project #658-038)	This project was not considered for FY 1984 in order that a comprehensive facility survey could be done to demonstrate a cost effective option for solving fire and safety, patient privacy and modernization deficiencies at this Medical Center. A number of buildings at the facility require renovation. The facility survey was determined necessary in order to evaluate whether complete replacement might be more cost effective and viable than individual building renovation projects, such as proposed by this project.

Project Location	Original Project Scope	Reason
W. Los Angeles (Wadsworth), CA	Renovate three existing domiciliary care buildings. (Project #691-090)	This project was not considered for FY 1984 in order to allow time for the Department of Medicine and Surgery's review and reevaluation of the mission and space criteria standards for the VA's domiciliary program to be finalized. Upon completion of this review, updated policy guidance will be issued to provide direction to the VA's domiciliary construction program. The FY 1984 review also found that renovation of only two of the buildings might be necessary based on an assessment of bed needs and workload.

NOTE: The 57 projects selected for review represented that list of projects in the early Spring of 1982 which could possibly have preliminary design and a cost target available by Fall 1982 in time for FY 1984 budget consideration. In formulating the list of these projects, the Department of Medicine and Surgery (DM&S) and the Office of Construction (O/C) advised at the outset that ongoing reevaluations of some of the projects and schedule delays and/or design problems on several others could preclude them from being possible candidates for review or FY 1984 funding consideration. Many of the 22 projects determined not ready for FY 1984 consideration are in these categories.

REGIONAL OFFICES WITHIN FIFTY MILES OF VA MEDICAL CENTERS

State	Distance in Miles	Facility Acreage
ALABAMA		
1. Montgomery Regional Office		
VAMC Montgomery	5.5	57.0
VAMC Tuskegee	38.0	159.3
ARIZONA		
2. Phoenix Regional Office		
VAMC Phoenix	1.0	23.1
ARKANSAS		
3. Little Rock Regional Office		
VAMC Little Rock Division	3.0	16.0
VAMC N Little Rock Division	4.0	162.4
CALIFORNIA		
4. Los Angeles Regional Office		
VAMC West Los Angeles:		
Brentwood	.25	150.0
Wadsworth	.25	292.4
VAMC Long Beach	30.0	100.3
VACM Sepulveda	30.0	160.0
5. San Diego Regional Office		
VAMC San Diego	14.0	26.0
6. San Francisco Regional Office		
VAMC San Francisco	7.0	29.2
VAMC Livermore	50.0	118.3
VAMC Martinez	35.0	25.8
VAMC Menlo Park	40.0	96.2
VAMC Palo Alto	50.0	92.8
COLORADO		
7. Denver Regional Office		
VAMC Denver	28.0	12.0
CONNECTICUT		
8. Hartford Regional Office		
VAMC Newington	6.0	42.8
DISTRICT OF COLUMBIA		
9. Washington Regional Office		
VAMC Washington	3.0	34.0

Sources: Mileage - Provided by VA Medical Centers
Acreage - Annual Report of Real Property

State	Distance in Miles	Facility Acreage
FLORIDA		
10. St. Petersburg Regional Office		
VAMC Bay Pines	10.0	336.9
VAMC Tampa	28.0	22.2
GEORGIA		
11. Atlanta Regional Office		
VAMC Decatur	7.5	26.5
IDAHO		
12. Boise Regional Office		
VAMC Boise	.1	67.32
ILLINOIS		
13. Chicago Regional Office		
VAMC Chicago:		
Lakeside (E. Huron St.)	3.0	3.8
West Side	4.0	15.6
VAMC N. Chicago (Downey)	30.0	221.5
VAMC Hines	15.0	146.5
INDIANA		
14. Indianapolis Regional Office		
VAMC Indianapolis:		
Cold Spring Rd. Division	4.4	30.0
West Tenth St. Division	2.3	18.8
IOWA		
15. Des Moines Regional Office		
VAMC Des Moines	5.0	47.3
VAMC Knoxville	40.0	162.9
KENTUCKY		
16. Louisville Regional Office		
VAMC Louisville	5.0	50.0
LOUISIANA		
17. New Orleans Regional Office		
VAMC New Orleans	1.0	6.6
MARYLAND		
18. Baltimore Regional Office		
VAMC Baltimore	5.0	15.0
VAMC Perry Point	39.0	478.2
VAMC Ft. Howard	13.0	94.6

State	Distance in Miles	Facility Acreage
MASSACHUSETTS		
19. Boston Regional Office		
VAMC Boston	18.0	13.2
VAMC Bedford	17.0	180.7
VAMC Brockton	23.0	145.7
VAMC West Roxbury	10.0	30.0
MICHIGAN		
20. Detroit Regional Office		
VAMC Allen Park	11.0	38.9
VAMC Ann Arbor	34.0	19.0
MINNESOTA		
21. St. Paul Regional Office		
VAMC Minneapolis	1.5	132.7
MISSISSIPPI		
22. Jackson Regional Office		
VAMC Jackson	5.0	28.4
MISSOURI		
23. St. Louis Regional Office		
VAMC John J. Cochran Div.	3.0	13.2
VAMC Jefferson Barracks Div.	20.0	143.8
NEBRASKA		
24. Lincoln Regional Office		
VAMC Lincoln	5.0	62.1
NEVADA		
25. Reno Regional Office		
VAMC Reno	1.0	12.5
NEW HAMPSHIRE		
26. Manchester Regional Office		
VAMC Manchester	2.0	32.0
NEW JERSEY		
27. Newark Regional Office*		
VAMC East Orange	5.0	32.2
VAMC Lyons	17.0	298.3

* Note - VAMC's within 50 miles of Newark Regional Office may also be within 50 miles of the New York Regional Office.

State	Distance in Miles	Facility Acreage
NEW MEXICO		
28. Albuquerque Regional Office		
VAMC Albuquerque	8.0	83.4
NEW YORK		
29. New York Regional Office*		
VAMC New York	1.5	6.4
VAMC Bronx	15.0	29.8
VAMC Montrose	49.0	215.3
VAMC Brooklyn:		
Brooklyn Division	12.0	17.1
St. Albans Division	16.0	63.2
VAMC Northport	50.0	350.4
30. Buffalo Regional Office		
VAMC Buffalo	7.0	16.9
VAMC Batavia	35.0	48.8
NORTH CAROLINA		
31. Winston-Salem Regional Office		
VAMC Salisbury	42.0	153.9
NORTH DAKOTA		
32. Fargo Regional Office		
VAMC Fargo	3.0	38.7
OHIO		
33. Cleveland Regional Office		
VAMC Cleveland:		
Brecksville Division	15.0	101.1
Wade Park Division	1.0	17.3
OKLAHOMA		
34. Muskogee Regional Office		
VAMC Muskogee	3.0	15.3
OREGON		
35. Portland Regional Office		
VAMC Portland:		
Portland Division	3.5	28.5
Vancouver Division	13.0	88.6
PENNSYLVANIA		
36. Philadelphia Regional Office		
VAMC Philadelphia	13.0	14.8
VAMC Coatesville	44.0	128.4
VAMC Wilmington (Medical & Regional Office)	33.0	30.6

* Note - VAMC's within 50 miles of New York Regional Office may also be within 50 miles of the Newark Regional Office.

State	Distance in Miles	Facility Acreage
PENNSYLVANIA (Cont.)		
37. Pittsburgh Regional Office		
VAMC Pittsburgh:		
Highland Drive	7.0	178.8
Aspinwall Division	8.0	50.0
University Drive	3.0	13.9
RHODE ISLAND		
38. Providence Regional Office		
VAMC Providence	1.5	40.4
SOUTH CAROLINA		
39. Columbia Regional Office		
VAMC Columbia	5.0	94.2
TENNESSEE		
40. Nashville Regional Office		
VAMC Nashville	2.0	17.2
VAMC Murfreesboro	41.0	396.7
TEXAS		
41. Houston Regional Office		
VAMC Houston	1.0	118.9
42. Waco Regional Office		
VAMC Waco	3.5	123.3
VAMC Temple	32.0	183.9
VAMC Marlin	34.0	7.9
UTAH		
43. Salt Lake City Regional Office		
VAMC Salt Lake City	3.5	120.6
VIRGINIA		
44. Roanoke Regional Office		
VAMC Salem	5.5	249.6
WASHINGTON		
45. Seattle Regional Office		
VAMC Seattle	3.0	33.8
WEST VIRGINIA		
46. Huntington Regional Office		
VAMC Huntington	8.0	99.8
WISCONSIN		
47. Milwaukee Regional Office		
VAMC Wood	5.0	213.5